

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 3 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lee ABBOTT  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 29, 1984 |   |  | 2b. HOUR<br>10:38P M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Blk   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 29 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74<br>YRS MONTHS DAYS HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Concord, VA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. Co.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Bethlehem Steel  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Md. |  | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>Edgemore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br>7217 Orth Rd. 21219  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Abbott  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Abbott  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                   |  | 16b. SOCIAL SECURITY NO.<br>.  |   | 17. INFORMANT<br>Nelda Dowdy  |  | ADDRESS<br>5014 Ready Ave.  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a) Severe Arterio Sclerotic Cardio-Vascular  
Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110.

MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from May 27, 19 84, to May 29, 19 84, that X (we) lost<br>saw the deceased alive on May 29, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) sew the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>M.E. Zeiton   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5/29/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M.E. ZEITOUNEH   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237   |  |   |  |

|   |  |                     |  |   |  |  |  |
|---|--|---------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial          |  | 23b. DATE<br>6-2-84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Obed Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Concord, VA. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JAS. A. MORTON 1701 LAURENS ST. |  |                     |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 31 1984        |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

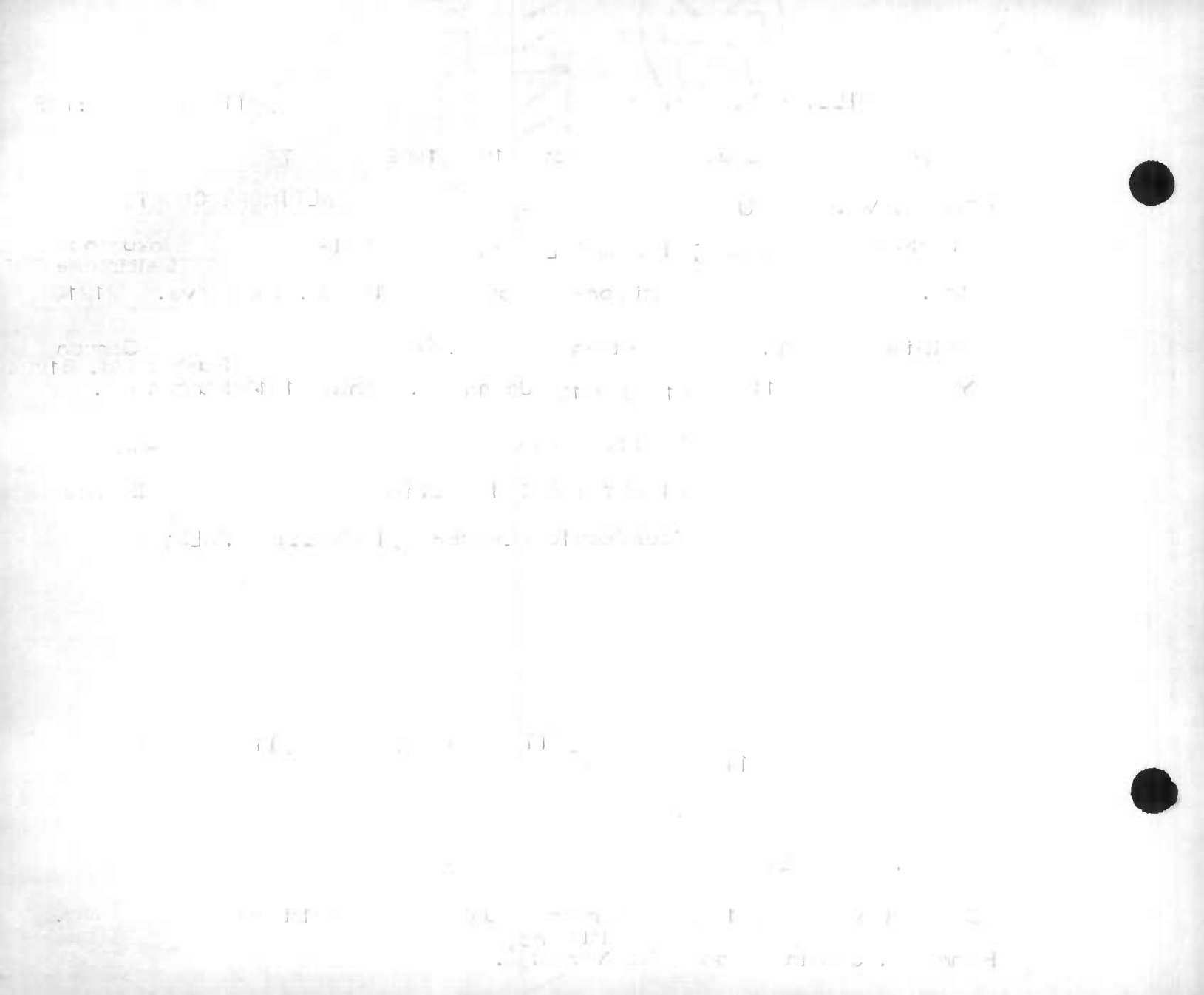
1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |   |                           |  |  |   |  |  |  |
|--|--|--|---|---|---------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM T. ADDISON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/11/84</b> |   | 2b. HOUR<br><b>6:10PM</b> |  |  |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 18 1909</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS                                 |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>74</b> YRS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>74</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Norfolk, Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.              |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N CHARLES ST</b> |   |   |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b><br><b>Baltimore Md.</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTIMORE</b>   |  |  |   |   |                           | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>109 W. Lake Ave. 21210</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William T. Addison</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Carson</b>   |                           |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> 16b. SOCIAL SECURITY NO.<br>(IF AKA, GIVE WAR OR DATES) <b>WW 11</b> <b>231 10 0217</b> |  |  |  |
| 17. INFORMANT<br><b>Joanne A. Schill</b>   |  |  |   | ADDRESS <b>Ruxton Md. 21204</b><br><b>1613 Ruxton Rd.</b>   |                           |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5968</b> IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>URINARY TRACT INFECTION</b><br>2 DAYS<br>(c) <b>NEUROGENIC BLADDER W/INDWELLING FOLEY</b>   |  |  |   |   |                           |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24HR</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  |  |  |   |   |                           |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                           |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> , 19 <b>84</b> , to <b>5/11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                           |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Dr. K. Byerly</i>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                           |  |  | 22c. DATE SIGNED<br><b>5/11/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. K BYERLY</b>   |  |  |   | 22e. ADDRESS<br><b>GBMC</b>   |                           |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |  |   | 23b. DATE<br><b>5-12-84</b>   |                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons 4905 York Rd.</b>   |  |  |   |   |                           | 25. DATE RECEIVED BY REGISTRAR<br><b>MAY 14 1984</b>                             |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "AT HOME" with any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HARRY A. ADOLPH, JR.                 |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 - 24 - 84                           |   | 2b. HOUR<br>15<br>9 AM   |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 20 13  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                       | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Summit NH. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attorney |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Soc. Services               |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry A. Adolph, Sr.              |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene Barber                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES |   | 16b. SOCIAL SECURITY NO.<br>WW II<br>220-14-8726  |  | 17. INFORMANT<br>ADDRESS<br>Dorothy M. Beaman 343 N. Charles St. 21201                          |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1550

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

Carcinoma of liver, metastasis.  
(b) Cardiac Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Cachexia 2° to Carcinoma

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|   |   |   |   |
|---|---|---|---|
| 19a. DATE OF OPERATION<br>—   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>—   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>— | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>— — — —  |   |
| 22a. I certify that (1) this hospital attended the deceased from 5-14 19 84 to 5-24 19 84, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |   |   |   |
| 22b. SIGNATURE<br>DP Malayan  |   | DEGREE<br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>5-24-84   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DP Malayan, MD   |   | 22e. ADDRESS<br>4001 Wilkens Ave, 21229   |   |

|  |                      |  |  |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                     | 23b. DATE<br>5/26/84 | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 |                      | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1984               | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

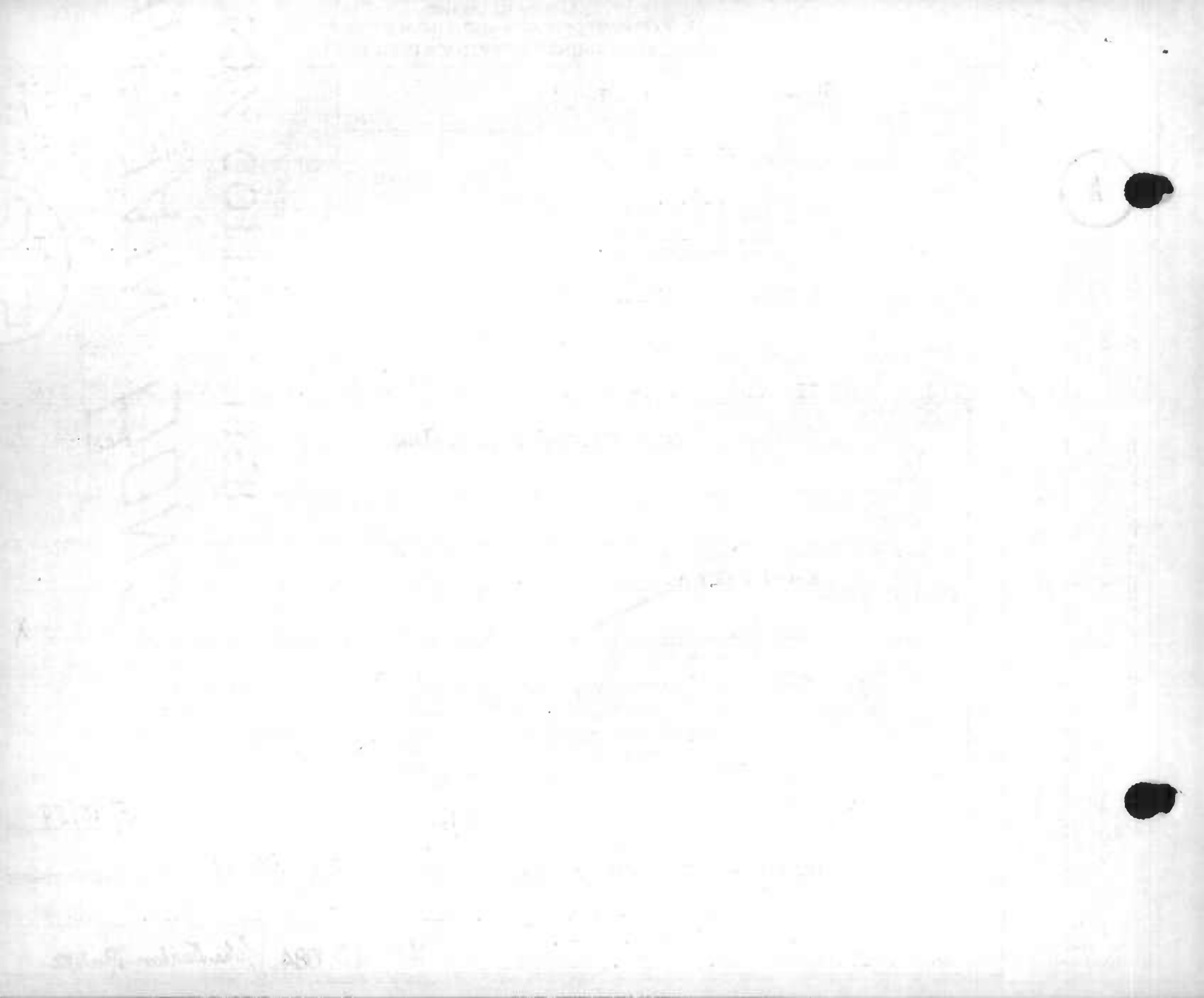


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH REG. 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |   |  | REG. NO.  |  |
|--|--|-------------------------|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harry Ageststein</b>  |  |                         |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <b>5</b> DAY <b>18</b> YEAR <b>1984</b> 2b. HOUR <b>2:38</b> P.M.  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>26</b> YEAR <b>1927</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>56</b> YRS.  |  | IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>5</b> DAY <b>18</b> YEAR <b>1984</b> 2d. HOUR <b>2:38</b> P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3725 LAMOINE RD.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COVERAGE EXAMINER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T.</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                         |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>RANDALLSTOWN</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3725 LAMOINE RD. #21133</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>MAX</b> MIDDLE <b>AGETSTEIN</b> LAST <b>AGETSTEIN</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>YETTA</b> MIDDLE <b>SUGARMAN</b> LAST <b>SUGARMAN</b> |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |  |                         |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>WW II ARMY</b>  |  | 17. INFORMANT<br><b>MRS. DOROTHY AGESTSTEIN</b><br><b>3725 LAMOINE RD., RANDALLSTOWN, MD 21133</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Emphysema</b>  |  |                         |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)              |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Stanley Z. Felsenberg MD</b>   |  |                         |  |   |  | TITLE (SPECIFY)<br>M.D. <b>Deputy</b>  |  | MEDICAL EXAMINER  |  | DATE SIGNED <b>5/18/84</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>STANLEY Z. Felsenberg MD</b>  |  |                         |  |   |  | ADDRESS <b>11 E. Chase St 21202</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>5-20-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OSHEB SHALOM MEM. PARK</b>                        |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b>                         |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 3 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST <b>Dawarka</b> MIDDLE <b>P.</b> LAST <b>Aggarwal</b><br><b>DAWARKA AGGARWAL</b> |  | 2a. DATE OF DEATH MONTH <b>05</b> DAY <b>06</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>1055</b> M   |
| 3. SEX <b>Male</b><br><b>MALE</b>   | 4. RACE <b>Indian</b><br><b>INDIAN</b>   | 5. DATE OF BIRTH MONTH <b>02</b> DAY <b>20</b> YEAR <b>08</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>76</b> DAYS <b>76</b> HOURS <b>76</b> MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>India</b><br><b>INDIA</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>INDIA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                          |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Not Applicable</b>    | 12b. KIND OF BUSINESS OR INDUSTRY                                       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                   |  |   |  |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Randallstown</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3925 McDonogh Rd. 21133</b>        |
| 14. FATHER'S NAME<br>FIRST <b>Karam</b> MIDDLE <b>Chand</b> LAST <b>Aggarwal</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>to Records</b> LAST <b></b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-02-2524</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Ram Mittal Same as # 13</b>          |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>DEHYDRATION</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
**MILD COPD, BIL INGUINAL HERNIA, Pneumonia**

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>-</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b> |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-</b> | 21f. LOCATION<br>STREET <b>-</b> CITY OR TOWN <b>-</b> COUNTY <b>-</b> STATE <b>-</b>      |   |

|   |  |  |                                   |
|---|--|--|-----------------------------------|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>05-03-1984</b> to <b>05-06-1984</b> , that (I) (we) last saw the deceased alive on <b>05-06-1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>[Signature]</b> DEGREE <b>-</b> | 22c. DATE SIGNED<br><b>5/6/84</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. SUDHIR PAEL</b>   |  | 22e. ADDRESS<br><b>BAL. COUNTY GEN. HOSP.</b>        |                                   |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                               | 23b. DATE<br><b>5/7/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b> | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville, Balto.</b> COUNTY <b>Md.</b> STATE <b>-</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MacNabb Funeral Home</b> ADDRESS<br><b>Catonsville, Md.</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1984</b>            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



LIBEL  
ON

LIBEL

LIBEL  
ON

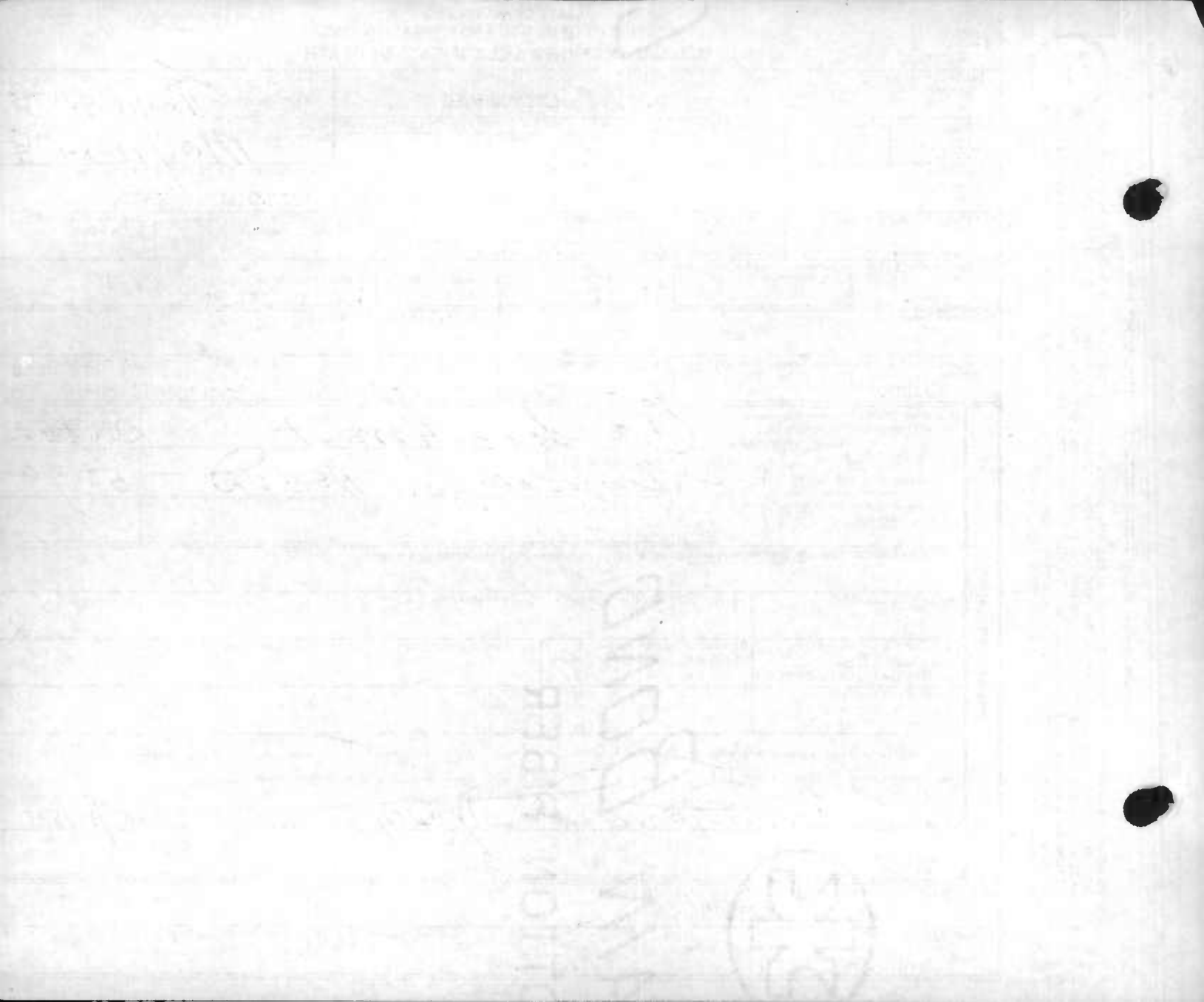
LIBEL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |               |  |  |  |                            |   |  |  |  | REG. NO.  |  |
|--|---------------|--|--|--|----------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE D. LAST ANTE TOMASO   |               |  |  |  |                            |   |  |  |  | 2a. DATE KNOWN OF DEATH MATED <u>May 11 1984</u> 2b. HOUR <u>7:15</u> M |  |
| 3. SEX Female  | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR <u>2 19 93</u>   | 6. AGE (IN YEARS) LAST BIRTHDAY <u>91</u> YRS. | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN | 7c. DATE PRONOUNCED DEAD <u>May 11 1984</u>                                       |  | 24 HOUR <u>7:15</u> M  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |               | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.                        |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH TOWSON   |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER |  |  |                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE Md.   |               | 13b. COUNTY Timonium   |  | 13c. CITY OR TOWN  |                            | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 102 Belfast Road <u>21093</u>                                |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |               |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                            |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.   |               |  |  | 16b. SOCIAL SECURITY NO. 219-28-6427   |                            | 17. INFORMANT ADDRESS 102 Belfast Road Ms. Antoinette Antetomaso Timonium, Md.    |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4292 Cardiac Arrest</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Renalized ASCVD</u><br>(b) <u>Renalized ASCVD</u><br>(c) <u>5+yo</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5+yo</u>  |               |  |  |  |                            |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |               |  |  |  |                            |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |               |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                            |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |               |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)     |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |               |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                            | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |               |  |  |  |                            |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D.   |               |  |  | MEDICAL EXAMINER   |                            |   |  | DATE SIGNED <u>5/11/84</u>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |               |  |  | ADDRESS  |                            |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal  |               | 23b. DATE 5/11/84  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                            | 23d. LOCATION CITY OR TOWN  |  | COUNTY STATE   |  |   |  |
| 24. FUNERAL DIRECTOR NAME Anatomy Board  |               |  |  | ADDRESS Balto., Md.  |                            | 25a. DATE REC'D. BY REGISTRAR MAY 18 1984   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                                    |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

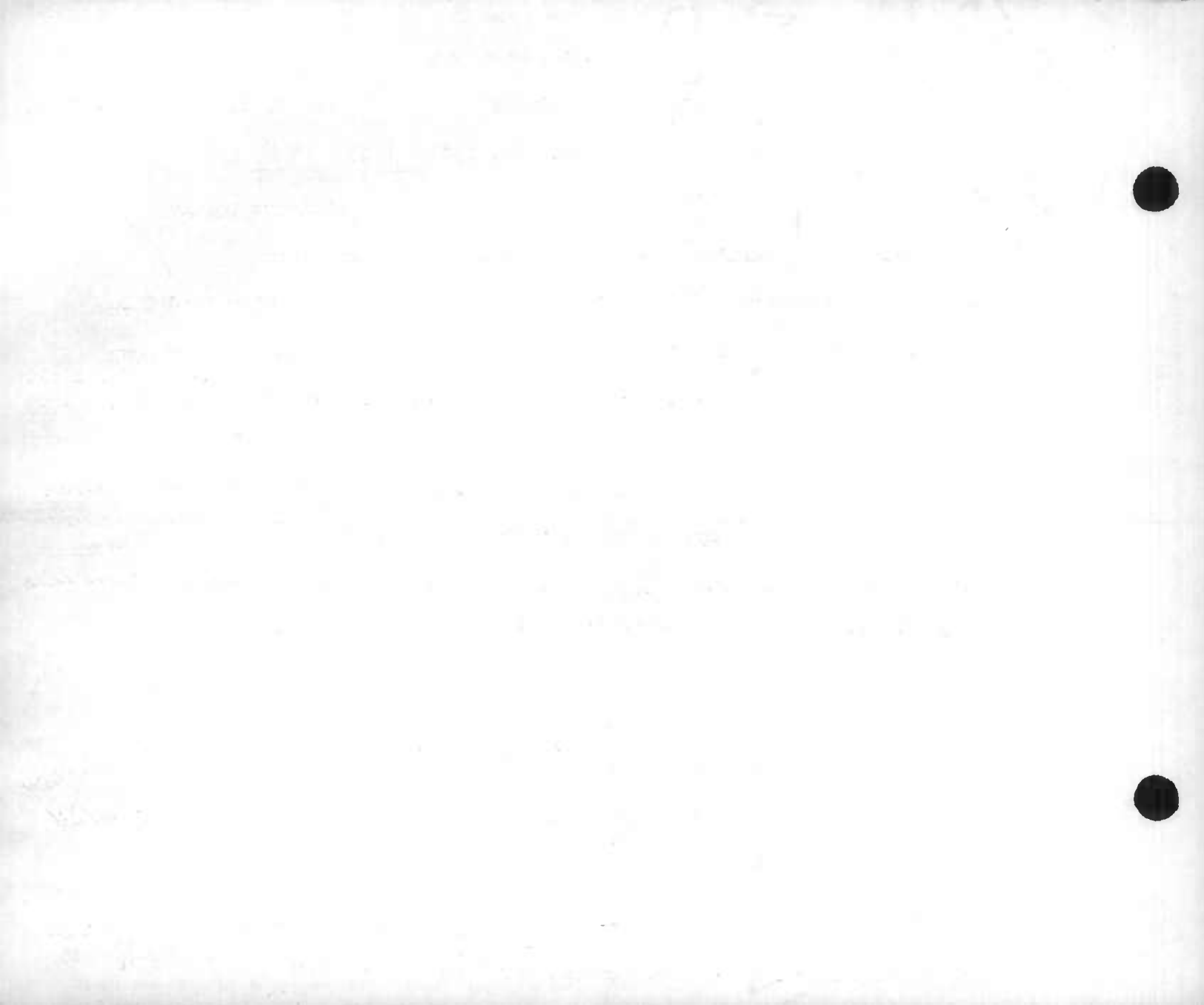
8 4 1 2 2 3 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |                                   |  |  |
|--|--|--|---|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GENEVIEVE S. ARNOLD</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 2, 1984</b> |   | 2b. HOUR<br><b>7:53 P.M.</b>   |  |                                   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 20, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b><br>YRS. MONTHS DAYS HOURS MIN.  |                                   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Pikesville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>4108 Colby Road 21208</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Krapp</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth unknown</b>  |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-52-8183</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Jean E. Miller 3910 Timber Ridge Place Midlothian, Va. 23113</b>  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac respiratory arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiogenic shock - complete heart block</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Inferior MI</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Old Anterior MI, Complete LBBB Chronic Lymphatic Leukemia</b>   |  |  |   |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION<br><b>5/2/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Temporary Pacemaker</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-2-84</b> , 19 <b>84</b> , to <b>5-2-84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5-2-84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |   |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br><b>E. C. Galvez</b>  |  |  |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/4/84</b>  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edito C. Galvez, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>5400 Old Court Road</b>  |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-5-1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1984</b><br>REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |  |                                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 42 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) <u>Arhontoulas</u> <sup>First</sup> <u>Athanasakos</u> <sup>Last</sup>  |  | 2a. DATE OF DEATH<br>Month <u>May</u> Day <u>30</u> Year <u>84</u>   |   | 2b. HOUR<br><u>11:30</u> <sup>A</sup> <sup>M</sup>             |   |
| 3. SEX<br><u>Female</u>   | 4. RACE<br><u>White</u>  | 5. DATE OF BIRTH<br><u>10/06/05</u>  | 6. AGE (in years<br>last birthday)<br><u>78</u> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (State or foreign<br>country) <u>Greece</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><u>Balto. Co.</u> Md.   |  |   |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <u>St. Joseph Hospital</u>   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of life, even if retired.) <u>Homemaker</u>  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <u>Md.</u>   | 13b. COUNTY <u>Balto. Timonium</u>   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <u>21093</u><br><u>102 Galewood Rd.</u> |   |
| 14. FATHER'S NAME First <u>Demetrios</u> Middle <u>Strategakos</u> Last <u>Kondilia</u>   | 15. MOTHER'S MAIDEN NAME First <u>Triantafilakos</u> Middle <u>Triantafilakos</u> Last <u>Triantafilakos</u> |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)   | 16b. SOCIAL SECURITY NO.<br><u>179-16-1505 A</u>   | 17. INFORMANT Address<br><u>Michael G. Athas 100 Galewood Road 21093</u>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u><br><u>1539</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CARCINOMA (COLON)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PNEUMONIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>4 1/2 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>77</u> , to <u>MAY</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>MAY 29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |
| 22b. SIGNATURE<br><u>Anthony A. Lewandowski M.D.</u> DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22c. DATE SIGNED<br><u>05-30-84</u>   |  |   |
| 22d. PHYSICIAN'S NAME (Type) <u>ANTHONY A. LEWANDOWSKI M.D.</u>   |  | 22e. ADDRESS<br><u>7402 York Rd. Ste 102 Towson Md 21204</u>   |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE<br><u>6-2-1984</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greek Orthodox</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Maryland</u>                      |  |   |
| 24. FUNERAL DIRECTOR<br><u>Ruck Towson Funeral Home, Inc. Towson, Maryland</u>  |  | 25a. REC'D BY REGISTRAR<br><u>JUN 4 1984</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Swisher</u>  |  |   |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |                   |  |   |                                   |  |                  |  |
|--|--|--|-------------------|--|---|-----------------------------------|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  | MIDDLE            | LAST   | 2a. DATE OF DEATH   | MONTH                             | DAY  | YEAR             | 2b. HOUR                                     |
| Ben  |  |  |                   | Augustin   | May   | 14                                | 84   |                  | 1:10 a                                       |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |  |
| Male   | White  | March 7 1906   |                   |  | 78  | MONTHS DAYS                       |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                   |  |                  |  |
| Poland   | USA  |  |                   |  | Baltimore County MD.  |                                   |  |                  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |  |
| Baltimore  | Franklin Square Hospital   |  |                   | Driller  |   |                                   |  |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE                                      |                                   |  |                  |  |
| Md.  |  |  | Balto.            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 3225 Elliott St. 21224  |                                   |  |                  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |                   |  |   |                                   |  |                  |  |
| Wincenty   |  | Augustynowicz  |                   | Helen  |   |                                   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT ADDRESS  |   |                                   |  |                  |  |
| NO   |  | 212-01-3402  |                   | Charles R. Rosiak 8301 Oakleigh Rd/  |   |                                   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                   |  |   |                                   |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |                   |  |   |                                   |  |                  |  |
| IMMEDIATE CAUSE (a) 1541 Cardiorespiratory Arrest  |  |  |                   |  |   |                                   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of Rectum   |  |  |                   |  |   |                                   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |                   |  |   |                                   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |  |                   |  |   |                                   |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                  |  |
|  |  |  |                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |                                   |  |                  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |                   |  |   |                                   |  |                  |  |
|  |  | P.M. 19  |                   |  |   |                                   |  |                  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |                   | 21f. LOCATION  |   |                                   |  |                  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   | STREET CITY OR TOWN COUNTY STATE   |   |                                   |  |                  |  |
| 22a. I certify that (this hospital) attended the deceased from April 13, 1984, to May 14, 1984, that (we) last saw the deceased alive on May 14, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death. |  |  |                   |  |   |                                   |  |                  |  |
| 22b. SIGNATURE   |  |  |                   | DEGREE   |   |                                   |  | 22c. DATE SIGNED |  |
| W. WALLACE   |  |  |                   | M.D.   |   |                                   |  | 5/14/84          |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |                   | 22e. ADDRESS   |   |                                   |  |                  |  |
| W. WALLACE   |  |  |                   | 9000 Franklin Square Drive., 21237   |   |                                   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION                     |  | 23e. STATE       |  |
| Burial   |  | 5-16-84  |                   | Holy Rosary Cem  |   | Balto.                            |  | Md.              |  |
| 24. FUNERAL DIRECTOR   |  |  |                   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE        |  |                  |  |
| John M. Weber & Sons Inc. 401 S. Chester St.   |  |  |                   | MAY 16 1984  |   | Lia Davidson-Rendell              |  |                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 4 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Julia H. Bajeronas</b>  |   | 2a DATE OF DEATH MONTH DAY YEAR<br><b>May 26, 1984</b>   |  | 7b HOUR<br><b>9:00p.m.</b>  |  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>Caucasian</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 11, 1904</b>  |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b> YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rossville</b>   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Cannery</b>  |  |
| 13a STATE<br><b>Maryland</b>   | 13b CITY OR TOWN<br><b>Baltimore</b>  | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d STREET ADDRESS / ZIP CODE<br><b>1913 Bank St. #21231</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Helinski</b>  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosalie Blachowicz</b>   |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   | 16b SOCIAL SECURITY NO.<br><b>213-01-3268</b>   | 17 INFORMANT ADDRESS<br><b>Antoinette C. Bajeronas- 1913 Bank St.</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>History of Myocardial Infarction</b>  |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Mitral Stenosis</b>   |   |  |  |   |  |
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 22, 1984</b> , to <b>May 26, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 26, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (not) view the body after death. |   |  |  |   |  |
| 22b SIGNATURE<br><b>Fernando J. Acle, M.D.</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c DATE SIGNED<br><b>5/26/84</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Fernando J. Acle, M.D.</b>  |   | 22e ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b DATE<br><b>5/30/84</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>George A. Weber &amp; Sons, Inc.</b>   |   | ADDRESS<br><b>705 S. Ann St.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 29 1984</b>  |  |
|  |   | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



X

X

X

X

X

X

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner should view the body after death.

FOR  
STATE  
REGISTRAR **XC 4 582 783**

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MICHAEL BARAN</b>                        |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 5, 1984</b>                                |   | 2b. HOUR<br><b>9:20 P.M.</b>                                   |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCTOBER 8, 1920</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CZECHOSLOVAKIA</b>                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF EMPLOYED</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Butcher</b>            |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>Dundalk</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>7621 CEDAR ROAD 21222</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Baran</b>                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Petrova</b>                    |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 215 01 3708</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>CLINICAL RECORDS, V.A.M.C., FORT HOWARD, MD</b>                  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIOPULMONARY ARREST**

4100  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **POSSIBLE PAINLESS MYOCARDIAL INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ASCVD AND DIABETIS**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAY 3</b> , 19 <b>84</b> , to <b>MAY 5</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above <b>MAY 5</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated. |  |  |  |
| 22b. SIGNATURE<br><i>Manoranjan P. Singh</i>   |  | 22c. DATE SIGNED<br><b>MAY 6, 1984</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANORANJAN P. SINGH, M.D.</b>  |  | 22e. ADDRESS<br><b>V.A.M.C. FORT HOWARD, MD 21052</b>                                |  |

|  |                              |  |   |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>5/9/1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gdns. Of Faith</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br>REGISTRAR'S SIGNATURE<br><b>MAY 8 1984 Julia Davidson-Randall</b> |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN L. BAST</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>20</b> YEAR <b>84</b> 2b. HOUR <b>11:18 P.M.</b>   |  |   |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>C White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>43</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b>   |   | IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> DAYS <b>HOURS</b> MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                        |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS HOSPICE-TOWSON-MD</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assist. Actuary</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Mutual Life Ins. Co.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS<br><b>24 Heathrow Manor Ct. 21236</b> |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>James</b> LAST <b>Bast</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mae</b> MIDDLE <b>Hawkins</b> LAST   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>Vietnam</b>   |  | 17. INFORMANT<br><b>Bast</b>  |   | 24. ADDRESS<br><b>24 Heathrow Manor Ct. Balto., Md. 21236</b>                              |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PANCREATIC CANCER</b><br>1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF              |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-18</b> , 19 <b>84</b> , to <b>5-20</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5-18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>K. Faulkner MD</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kendall R. Falkner-M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>2300 Dulany Valley Rd -21204</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>5-21-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Maryland</b> STATE                             |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Stasch 7H 7401 Belair Rd.</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 25 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 4 3

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |                     |   |   |  |  |
|--|---------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>DOROTHY M BATHON</u>  |                     |   | 2a. DATE OF DEATH<br>MONTH <u>5</u> DAY <u>5</u> YEAR <u>84</u>                                 |  | 2b. HOUR<br><u>8:40</u> AM                     |
| 3. SEX<br><u>F</u>   | 4. RACE<br><u>W</u> | 5. DATE OF BIRTH<br>MONTH <u>June</u> DAY <u>29</u> YEAR <u>1916</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>67</u> YRS.  | 7. UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County, MD</u>                          |  |
| 10. CITY OR TOWN OF DEATH<br><u>Randallstown</u>   |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore County General Hospital</u>     |   | 12. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>PBX Operator</u>       |  |
| 13a. STATE<br><u>Maryland</u>  |                     | 13b. CITY OR TOWN<br><u>Baltimore</u>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><u>18 Summerfield Road, 21207</u>                          |  |
| 14. FATHER'S NAME<br>FIRST <u>John</u> MIDDLE <u>Rolston</u> LAST <u></u>  |                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Lena</u> MIDDLE <u></u> LAST <u>Thiale</u>                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR (UNKNOWN))<br><u>No</u>  |                     | 16b. SOCIAL SECURITY NO.<br><u>N/A</u>  |   | 17. INFORMANT<br>ADDRESS <u>21207</u><br><u>Bonnie B. Geary, 18 Summerfield Road,</u>        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br><u>4100</u> IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia - Exsis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ventilator related pneumonia</u> <u>2 hrs</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Escherichia coli Infection</u> <u>20 days</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                     |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>CVA Aphasia</u>   |                     |   |   |  |  |
| 19a. DATE OF OPERATION<br><u>N/A</u>   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>XIP</u>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF OTHER, NOTIFY MEDICAL EXAMINER)   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>N/A</u> <u>19</u>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>N/A</u> |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, ETC.)<br><u>N/A</u>  |   | 21f. LOCATION<br>STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> 19 <u>84</u> to <u>5/5</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>5/5</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we) did not see the body after death)   |                     |   |   |  |  |
| 22b. SIGNATURE<br><u>Matth Redmond</u>   |                     | DEGREE <u></u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>5/5/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Matth Redmond</u>  |                     | 22e. ADDRESS<br><u>1 EAST Cherry Hill Rd. 2136</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |                     | 23b. DATE<br><u>5/8/84</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cemetery</u>                               |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br><u>Woodlawn, Baltimore CO, Md</u>   |                     | 23e. COUNTY<br><u>Baltimore</u>   |   | 23f. STATE<br><u>Md</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>WOODLAWN MEMORIAL F.H., 6111 Windsor Mill Rd.</u>   |                     | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 18 1984</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Lia Davidson-Randall</u>                                    |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/cremation permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NORMA V. BAUER |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-16-84 |   |  | 2b. HOUR<br>1540 M  |  |
| 3. SEX<br>Female                                      |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 23, 1921  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  |
|   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                 |  |

|  |  |                             |  |  |  |   |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|---|--|
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore    |  | 13c. CITY OR TOWN<br>21239                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1414 Register Ave., 21239 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Raymond C. Kennard, Sr.          |  |                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leora V. Boykin |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | (IF YES, GIVE WAR OR DATES) |  | 16b. SOCIAL SECURITY NO.<br>212 09 9924                          |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Norma L. Arcilesi, Rockville, MD                               |  |   |  |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

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DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) 11500

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DAYS

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-16-84 to 5-16-84, that (I) (we) lost<br>saw the deceased alive and that (I) (we) found the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>RICHARD D. B. 1995  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5-16-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD D. B. 1995   |  |  |  | 22e. ADDRESS<br>7600 OSLER DR  |  |   |  |

|  |  |                      |  |  |  |   |  |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>5/19/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County, MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212 |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 17 1984         |  |   |  |
|  |  |                      |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT ANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 4 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA M. BAUERS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 25 84</b>  |  | 2b. HOUR<br><b>840 AM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 04 93</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.,</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House Keeper</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Church</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Overlea</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>8 E. Overlea Avenue 21206</b>                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Schmitt</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Kraus</b>                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-22-4628</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, Md.</b>                                    |  |
| 16c. REGISTERED ADDRESS<br><b>Margaret Zoll 608 Register Ave 21212</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4960 IMMEDIATE CAUSE (a) PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>senile dementia</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/27/84</b> , 19 <b>84</b> , to <b>5/25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>R Faulkner</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>5/25/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Faulkner</b>  |  | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>2300 Delany Valley Rd / Towson 21204</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>May 29, 84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery Baltimore, Maryland</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Funeral Homes, Inc.</b>   |  | ADDRESS<br><b>7110 Belair Road<br/>Baltimore, Md.</b>   |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 28 1984</b>                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |                                   |
|---|--|---|--|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George F. Harold Baxter  |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 28, 1984  |  | 7b. HOUR<br>4:30 P.M.             |
| 3. SEX<br>Male  | 4. RACE<br>white   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 28, 1902   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                 |  |                                   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Forman Glidden Paint Co. |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br>2707 Burr Ridge RD. 21234                                  |  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harvey Baxter.  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth ?   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                   |  |                                   |
| 16b. SOCIAL SECURITY NO.<br>216-01-9366A  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Myrtle L. Baxter 2707 Burr Ridge Rd. 21234   |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4254 IMMEDIATE CAUSE (a) <u>Cardiomyopathy, Congestive Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease &amp; Nephrosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus Unstable</u> |  |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>3/21/84 Left Leg Amputated Above Knee  |  |   |  |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                   |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>WHILE <input type="checkbox"/> NOT AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1972</u> to <u>May 1984</u> , that (I) (we) last saw the deceased alive on <u>5/21/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) signed and saw the body after death.                                     |  |   |  |  |                                   |
| 22b. SIGNATURE<br><u>Frank T. Kasik Jr.</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>5/29/84  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK T. KASIK JR MD   |  | 22e. ADDRESS<br>9005 HARFORD RD BALTIMORE 21234   |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>6/1/1984  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                            |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc 5305 Harford Rd/21214   |  | 25. DATE REC'D. BY REGISTRAR<br>JUN 1 1984  |  |  |                                   |
| 26. REGISTRAR'S SIGNATURE<br><u>Leonard J. Ruck</u>   |  | 27. REGISTRAR'S SIGNATURE<br><u>Leonard J. Ruck</u>   |  |  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance and that it has not been completely solved. The author then proceeds to a detailed analysis of the problem, showing that it is a special case of a more general problem. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient. The author then concludes the paper by stating that the problem has been solved, and that the method proposed in this paper is the most efficient.


2. The second part of the paper is devoted to a detailed analysis of the problem. It is shown that the problem is a special case of a more general problem. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient. The author then concludes the paper by stating that the problem has been solved, and that the method proposed in this paper is the most efficient.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  | REG. NO.   |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BECKER</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 1, 1984</b>   |  | 2b. HOUR<br>MIN.<br><b>6:32am</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 1, 1984</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.<br><b>15</b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland</b> <b>Harford</b> <b>Bel Air</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1108 Oakridge Court</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Joseph Becker, III</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Donna Lea Ault</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 17. INFORMANT<br>Bel Air, Maryland 21014<br><b>Donna Becker-1108 Oakridge Court</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br><b>7651</b> IMMEDIATE CAUSE (a) <b>Delivered In 23rd Week Maternal Gestation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1984</b> to <b>May 1, 1984</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>5/1/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G.A. Glowacki, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Disposed To Hospital</b>  |  | 23b. DATE<br><b>5/1/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Franklin Sq. Hosp.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>9000 Franklin Sq. Dr. 21237</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 25 1984</b>  |  |  |  |

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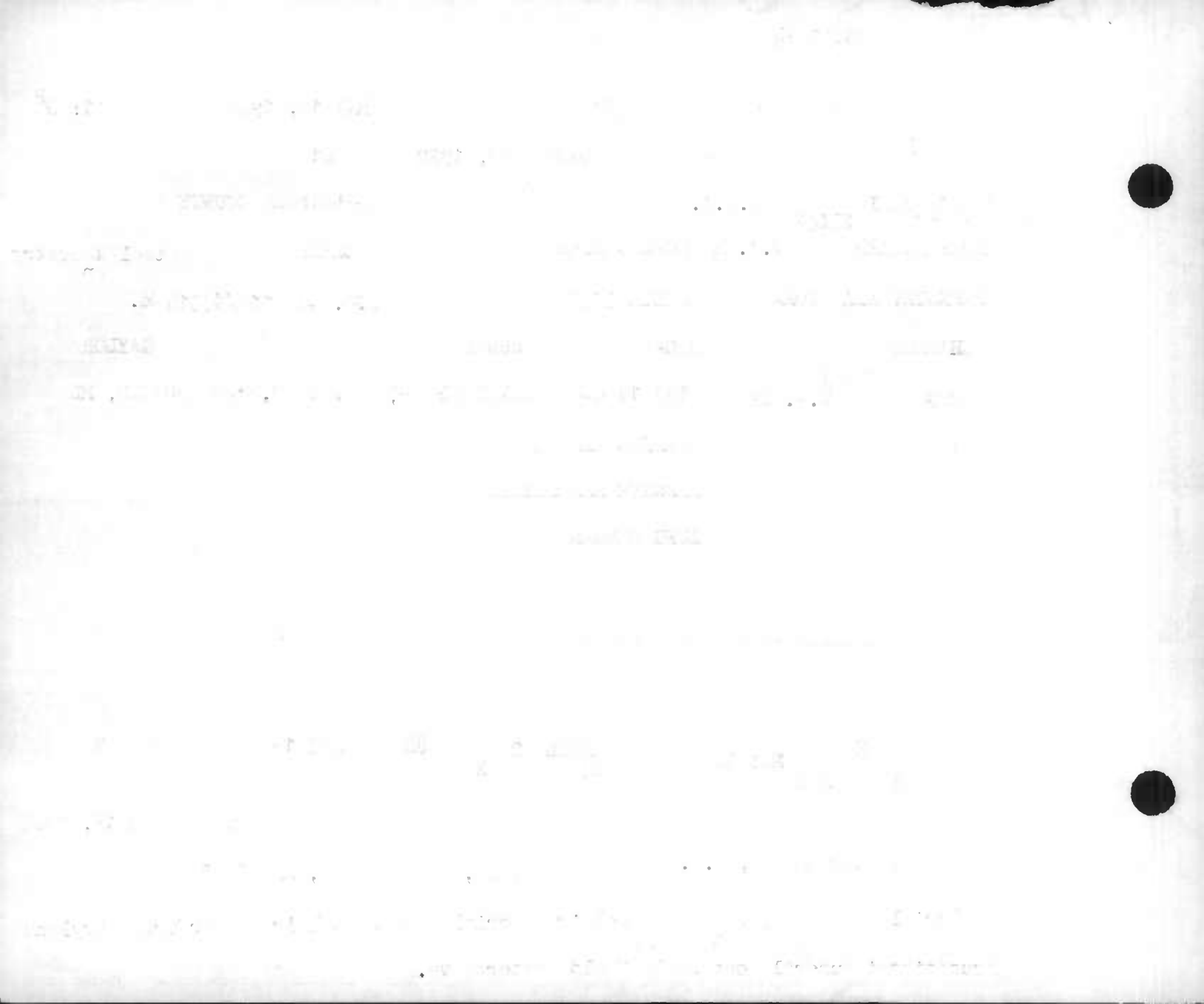
1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked "X", it is marked "X" for any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT CHARLES BECKER</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 14, 1984</b>   |  |  |  |
| 3. SEX <b>MALE</b>   |  |   |  | 2b. HOUR <b>11:50</b> P <sub>M</sub>  |  |  |  |
| 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 29, 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V.A. MEDICAL CENTER</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Industry</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br><b>PENNSYLVANIA YORK</b>   |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13d. CITY OR TOWN<br><b>DELTA 17314</b>  |  |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Box 115 Juniper Rd.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES BECKER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SUSAN GAYLOR</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES W.W. II</b>                                      |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>193 14 4084</b>   |  | 17. INFORMANT<br><b>Mae Becker, Wife</b>  |  |   |  | ADDRESS<br><b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE HEMOPHYSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LUNG CANCER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APRIL 2</b> 19 <b>84</b> to <b>MAY 14</b> 19 <b>84</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.                       |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>P. Campo Chiari M.D.</i>  |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>MAY 15, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER CAMPOCHIARO, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>VAMC, FORT HOWARD, MD 21052</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/18/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Belair Memorial Gardens</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harford Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><i>Brudzinski Funeral Home</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked "yes" above, injury, or other traumatic event, the medical examiner must use the following space to describe the event.)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  | REG. NO.             |   |
|---|--|---|---|--|----------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GWE NDOLYN F. BELSCHNER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 5 84 |  | 2b. HOUR<br>11:40 AM |   |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 24 17   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>67 YRS.   |                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |                      |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>GBMC-6701 N. CHARLES STREET |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |                      | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                      |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SCOTT FOWBLE  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BELLE SAUERWALD  |   |  |                      |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212 07 5003   |   | 17. INFORMANT<br>ADDRESS<br>BONNIE THOMPSON 1103 WELDON AVE. 21211   |                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PNEUMONIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |  |                      |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                      |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                      |   |
| 22b. SIGNATURE<br>* <i>Timothy E. Herlihy</i>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                      | 22c. DATE SIGNED<br>5/6/84  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TIMOTHY E. HERLIHY, M.D.   |  |   |   | 22e. ADDRESS<br>GBMC-6701 N. CHARLES STREET  |                      |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>MAY 8, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MORELAND MEMORIAL PARK   |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE COUNTY, MD.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>BURGEE FUNERAL HOME BALTIMORE 21211   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 7 1984  |                      | 25b. REGISTRAR SIGNATURE<br><i>John Davidson-Randall</i>  |

YTH000 280211



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |   |  | REG. NO.                                     |                                   |                     |  |
|--|--|---|---|---|--|--|--|---|--|--|-----------------------------------|---------------------|--|
| 1. FOR STATE REGISTRAR   |  |   | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Peter Daniel Bender SR |   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 6, 1984  |  |                                   | 2b. HOUR<br>5:28p M |  |
| 3. SEX<br>M  |  | 4. RACE<br>W  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/05/10   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |                                   |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |  |  |                                   |                     |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. |   |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STEEL |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                     |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTO.   |   | 13c. CITY OR TOWN<br>ESSEX  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>602 ALMOND AVE. 21221                   |  |  |                                   |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>VICTOR BENDER  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH ZABL   |  |  |  |   |  |  |                                   |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK  |  |   |   | 16b. SOCIAL SECURITY NO.<br>215 09 7615   |  | 17. INFORMANT<br>ADDRESS<br>MONICA BENDER ABOVE  |  |   |  |  |                                   |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Peritonitis, Acute.</u><br><u>5325</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Perforated Duodenal Ulcer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                   |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |  |  |  |   |  |  |                                   |                     |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)   |  |   |  |  |                                   |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |                                   |                     |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 27</u> , 19 <u>84</u> , to <u>May 6</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 6</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |   |   |  |  |  |   |  |  |                                   |                     |  |
| 22b. SIGNATURE<br><u>James Sides M.D.</u>  |  |   | DEGREE<br>M.D.  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><u>5/6/84</u>  |  |                                   |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James Sides, M.D.   |  |   | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237                                 |   |  |  |  |   |  |  |                                   |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>5/10/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                  |  |  |                                   |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.L. CONNELLY  |  |   | ADDRESS<br>300 MACE   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell                      |  |  |                                   |                     |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                                |  |  |
|---|--|---|---|---|--------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELIZABETH LENORE BENSON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 5, 1984</b> |   | 2b. HOUR<br><b>9:15 P</b><br>M |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 15, 1901</b>  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>82</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holly Hill Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles H. Wild</b>  |  | 15. MOTHER'S MIDDLE NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Pfaff</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3811 Canterbury Rd. 21218</b>  |                                | Apt. 412   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217 46 0440</b>  |   | 17. INFORMANT<br><b>Comley B. Springer, Johnstown, PA</b>   |                                | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1579 metastatic Ca</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ca pancreas</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 wks med.</b> |  |   |   |   |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |                                |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                                |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/30/84</b> to <b>5/5/84</b> , that (I) (we) lost saw the deceased alive on <b>5/3/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |   |   |                                |  |  |
| 22b. SIGNATURE<br><b>William F. Fritz</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                | 22c. DATE SIGNED<br><b>5/7/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William F. Fritz, M.D.</b>  |  | 22e. ADDRESS<br><b>2 W. University Pkwy., Balto., MD</b>  |   |   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/8/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |                                | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| ADDRESS<br><b>4905 York Road Balto., MD 21212</b>   |  |   |   |   |                                |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in your office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is mortuary or other traumatic event, the medical examiner will be notified and the death certificate will be subject to review.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hilda E. BERK  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 5 - 28 - 84                        |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 14, 1903   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7930 Berk Lane |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>7930 Berk Lane 21237  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank E. Schuh  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophia Fischer   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-48-0496  |   | 17. INFORMANT<br>ADDRESS<br>Mr. Robert P. Berk 7928 Berk Lane                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1830 IMMEDIATE CAUSE (a) METASTATIC OVARIAN CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4, 19 84, to 5/25, 19 84, that (I) (we) lost saw the deceased on 5/25, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br>DEGREE<br>Donald R. Richter MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   |   |   | 22c. DATE SIGNED<br>5-29-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD R. Richter  |   | 22e. ADDRESS  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>May 31, 1984   | 23c. NAME OF CEMETERY OR CREMATORY<br>Zion Lutheran Church  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rosedale Balto. Md.                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Maryland  |   |   |   | 25. DATE REC'D. BY REGISTRAR<br>JUN 1 1984  |  |
|   |   |   |   | 26. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 about any injury or other traumatic event, the medical examiner must be notified at once.

12-12-12

2/1/38

3

06/14



PROBATION DEPARTMENT

X



12-12-12

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified as follows:

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 5 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>MORRIS</b> MIDDLE <b>M.</b> LAST <b>BERMAN, SR.</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>5</b> YEAR <b>1984</b>   |  | 2b. HOUR<br><b>12:17A</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>May <b>1</b> , 1896 YEAR   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>88</b> DAYS <b>88</b>   |  | 8. IF UNDER 24 HRS.<br>HOURS <b>88</b> MIN. <b>88</b>  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 12. CITY OR TOWN<br><b>TOWSON</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |  | 14. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>  |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE <b>Maryland</b> 15b. COUNTY <b>Baltimore</b> 15c. CITY OR TOWN <b>Essex</b> 15d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/> |  | 16. STREET ADDRESS, 7 ZIP CODE<br><b>100 S. Marilyn Ave. 21241</b>  |  | 17. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>  |  |
| 18. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST <b>Fannie</b> MIDDLE <b>?</b> LAST <b>Unknown</b>   |  | 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW1</b>   |  |
| 21. SOCIAL SECURITY NO.<br><b>217 05 4385</b>  |  | 22. INFORMANT<br><b>Morris M. Berman, Jr. Son</b>   |  | 23. ADDRESS<br><b>Same</b>   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a) **Cold/pulmonary arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (we) (hospital) attended the deceased from <b>5/1/84</b> , 19 <b>84</b> , to <b>5/5/84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/1/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gregory J. Conpher</b>  |  | 22c. DEGREE<br><b>MD</b>   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22e. DATE SIGNED<br><b>5/5/84</b>  |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gregory J. Conpher</b>   |  | 22g. ADDRESS<br><b>St. Pops.</b>                                       |  |   |  |  |  |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                |  | 23b. DATE<br><b>5/8/84</b>                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> |  | 23d. LOCATION<br><b>Baltimore Md.</b> COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br><b>Przedzinski Funeral Home PA 1407 Old Eastern Ave</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 9 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Wardson-Wardell</b>      |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DPHM-17  
(VR A15 ME (3))  
30M 7/73

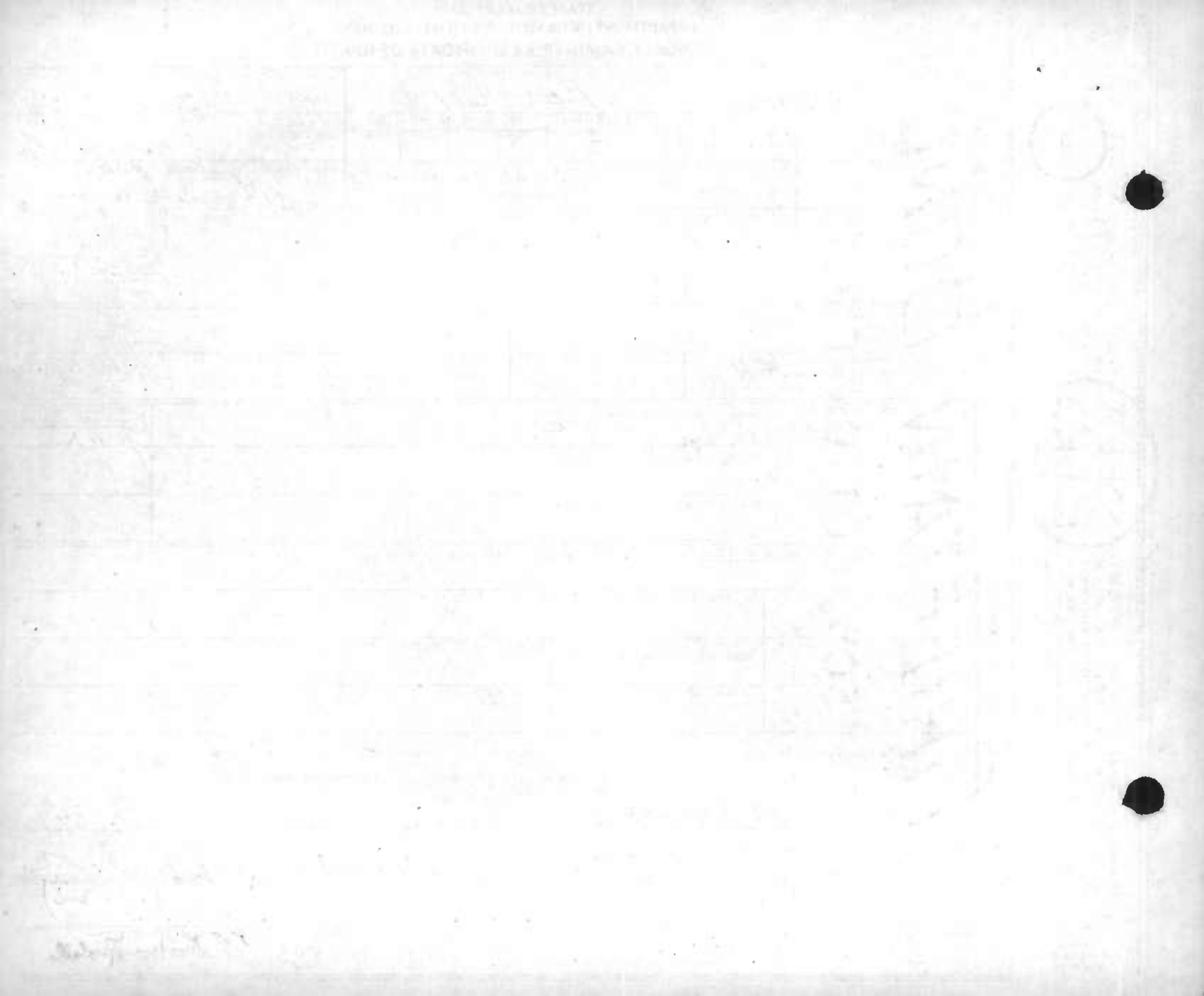
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                  |  |   |  |   |  |   |  |                                  |  |  |  |              |  |   |  |   |  |                     |  |
|---|--|------------------|--|---|--|---|--|---|--|----------------------------------|--|--|--|--------------|--|---|--|---|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>SAMUEL  |  | MIDDLE<br>BESDEN  |  | LAST<br>BESDEN                                |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED   |  | MONTH<br>5                       |  | DAY<br>2   |  | YEAR<br>1984 |  | 2b. HOUR<br>2:40 PM                                       |  |   |  |                     |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH<br>OCT. 5, 1916  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>67 YRS. |  | IF UNDER 1 YR.<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN |  | 7c. DATE<br>PRONOUNCED<br>DEAD   |  | MONTH<br>5   |  | DAY<br>2  |  | YEAR<br>1984  |  | 2d. HOUR<br>2:40 PM |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Penna.  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                 |  |              |  |   |  |   |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN. HOSP. |  |   |  |   |  |                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>SALESMAN |  |              |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>GARMENT           |  |   |  |                     |  |
| 13a. STATE<br>PENNA.  |  |                  |  | 13b. CITY OR TOWN<br>DELAWARE   |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                  |  | 13d. STREET ADDRESS<br>BROOMALL, PA.<br>333 CANDLEWOOD RD. (19008)           |  |              |  |   |  |   |  |                     |  |
| 14. FATHER'S NAME<br>FIRST<br>ABRAHAM   |  |                  |  | MIDDLE<br>BESDEN  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>DORA   |  |                                  |  | MIDDLE<br>UNKNOWN  |  |              |  |   |  |   |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES  |  |                  |  | (IF YES, GIVE WAR OR DATES)<br>WWII ARMY  |  |   |  | 16b. SOCIAL SECURITY NO.<br>160-10-8335   |  |                                  |  | 17. INFORMANT<br>RUTH BESDEN   |  |              |  | ADDRESS<br>333 CANDLEWOOD RD. (19008)                     |  |   |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 A. sev. O.<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |   |  |   |  |   |  |                                  |  |  |  |              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>7 days |  |   |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                  |  |   |  |   |  |   |  |                                  |  |  |  |              |  |   |  |   |  |                     |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |                                  |  |  |  |              |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                     |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                                  |  |  |  |              |  |   |  |   |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |                                  |  |  |  |              |  |   |  |   |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |                                  |  |  |  |              |  |   |  |   |  |                     |  |
| ACTUAL<br>SIGNATURE<br>E.P. Williamson  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy<br>MEDICAL EXAMINER  |  |   |  | DATE<br>SIGNED<br>5/2/84  |  |                                  |  |  |  |              |  |   |  |   |  |                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>E.P. Williamson   |  |                  |  | ADDRESS<br>5550 BALTO AVE. PK-BALTO.  |  |   |  |   |  |                                  |  |  |  |              |  |   |  |   |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>REMOVAL/CREMATION  |  |                  |  | 23b. DATE<br>5/4/84   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHELTEN HILLS CEM.  |  |                                  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>PHILA., PENNA.                    |  |              |  |   |  |   |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)  |  |                  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984   |  |                                  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                          |  |              |  |   |  |   |  |                     |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |                   |  |                          |   |  |
|--|--|--|-------------------|--|--------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |                   | 2a. DATE OF DEATH MONTH DAY YEAR   |                          | 2b. HOUR  |  |
| MAGGIE   |  | BIRDSALL   |                   | 5-8-84   |                          | 10 45 AM  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                          | IF UNDER 1 YEAR MONTHS DAYS   |  |
| FEMALE   | COL  | 6-23-09  |                   | 74 YRS.  |                          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                          |   |  |
| NORTH CAROLINA   | U.S.A.   |  |                   | BALTIMORE COUNTY MD.   |                          |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| TOWSON   | STELLA MARIS HOSPICE   |  |                   | HOMEMAKER  |                          |   |  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS      |   |  |
| MARYLAND   |  |  | BALTIMORE         |  | 740 POPPARGROVE ST 21216 |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |                   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                          |   |  |
| GREEN STACY  |  |  |                   | BETTY LINSKY   |                          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT ADDRESS  |                          |   |  |
| NO   |  |  |                   | MRS FRANKSTINE SMITH 2953 CLETON AVE 21216   |                          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RECTAL BLEEDING</u><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PANCREATIC TUMOR - PROBABLE CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RENAL FAILURE WITH AZOTEMIA</u> |  |  |                   |  |                          |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Renal failure Azotemia</u>  |  |  |                   |  |                          |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                          |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                          |   |  |
| 22a. I certify that (1) this hospital attended the deceased from 5-5 19 84 to 5-8 19 84, that (1) (we) last saw the deceased alive on 5-7 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.                           |  |  |                   |  |                          |   |  |
| 22b. SIGNATURE <u>R. Faulkner MD</u> DEGREE  |  |  |                   | 22c. DATE SIGNED   |                          | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |
|  |  |  |                   | 5/8/84   |                          | STELLA MARIS HOSPICE  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| BURIAL   |  | 5-12-84  |                   | ARBUS MAMPK  |                          | BALTO CO MD   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |                   | 25a. DATE REC'D. BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE  |  |
| JOSPHIN L. RUSSELL 2222 W. NORTH AVE   |  |  |                   | MAY 22 1984  |                          | Julia Davidson  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 (a) has any injury, or other traumatic event, the medical examiner must be notified of course.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 5 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul Herbert Black                               |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 26, 1984 |   |  | 2b. HOUR<br>P<br>4:25 M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>February 28, 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Timonium   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>25 Ballyhaunis Court 21093 |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Management                  |  |
|   |  |   |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipyard   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Timonium   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br>25 Ballyhaunis Court #21093                           |  |   |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert Ady Black                             |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Catherine Shimmin   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>213-07-1150   |   | 17. INFORMANT<br>ADDRESS<br>Timonium 21093<br>Ballyhaunis Ct.   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) - Pulmonary Failure<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) carcinoma of lung<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|   |  |   |  |                               |  |
|---|--|---|--|-------------------------------|--|
| 27b. SIGNATURE<br><i>Stanley Morrison</i>                       |  | DEGREE  |  | 27c. DATE SIGNED<br>27 May 84 |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stanley Morrison, M.D. |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                               |  |
| 27e. ADDRESS<br>11701 Woodland Drive, Lutherville, Md. 21093    |  |   |  |                               |  |

|  |  |                      |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                       |  | 23b. DATE<br>5/28/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Balto. Co., Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson, 10 W. Padonia Rd. Timonium |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 31 1984             |  | 25b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 5 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |   |  |  |
|--|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Emma Loretta Blick                     |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 4, 1984 |   |  | 2b. HOUR<br>5:14p M   |   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 05 22  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>----- |  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTIMORE                        |   | 13c. CITY OR TOWN<br>WHITE MARSH                             |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>11540 PHILADELPHIA RD. 21162             |  |   | 14. FATHER'S NAME<br>ROBERT MIDDLE MAXWELL      |   |  | 15. MOTHER'S MAIDEN NAME<br>LORETTA MIDDLE LAST -----                         |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  |   | 16b. SOCIAL SECURITY NO.<br>215140321           |   | 17. INFORMANT<br>ROBERT BLICK 11540 PHILADELPHIA RD. ADDRESS |   |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY ARREST

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Immed

1629  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF:

(b)

CARCINOMATOSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

SMALL CELL CARCINOMA of LUNG

6 weeks

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/4/84 to 5/4/84, that (I) (we) lost<br>saw the deceased alive on 5/4/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Naem Gauhar  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5/6/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NAEEM GAUHAR  |  | 22e. ADDRESS<br>5400 old Court Rd, Randallstown, Md.                   |  |  |  |   |  |

|  |  |                           |  |   |  |   |  |
|--|--|---------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>5/8/84       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FOREST VA REISTERTOWN BALTO. MD. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. J. Hall |  | ADDRESS<br>1211 Chemo Ave |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 7 1984                                     |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM C BOND</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 11, 1984</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 23, 1906</b>  |  | 6. AGE [IN YEARS LAST BIRTHDAY]<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner -Building</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Materials</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 13c. CITY OR TOWN<br><b>Towson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>204 E. Joppa Road 21204</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H. Bond</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Odelia Julier</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-6713</b>  |  |
| 17. INFORMANT<br><b>Irma V. Bond - Same AS #13e</b>  |  | ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Inferior Myocardial Infarct</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/5</b> 19 <b>84</b> , to <b>5/11</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/11</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |
| 22b. SIGNATURE<br><b>B. K. Yorkoff</b>   |  | 22c. DATE SIGNED<br><b>5/14/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Benjamin K. Yorkoff, M.D.</b>  |  | 22e. ADDRESS<br><b>7401 Osler Drive 7600</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-14-84</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium, Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1984</b>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 5 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Annabelle Booth                     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 19 84 |   |  | 2b. HOUR<br>4:00 P.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 9 1900  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2026 Codd Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Ferguson                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Not Known  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>210-20-0403   |  | 17. INFORMANT<br>Howard A. Booth  |  | ADDRESS<br>Same as 13e  |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cachexia

2449

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Hypothyroidism

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5, 1976, to present, 19, that (I) (we) last saw the deceased alive on 5-2-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Daniel P. Zujano MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID P. ZAJANO MD.  |  |  |  | 22e. ADDRESS<br>FRANKLIN SQUARE HOSPITAL, BALTO MD 2123  |  |  |  |

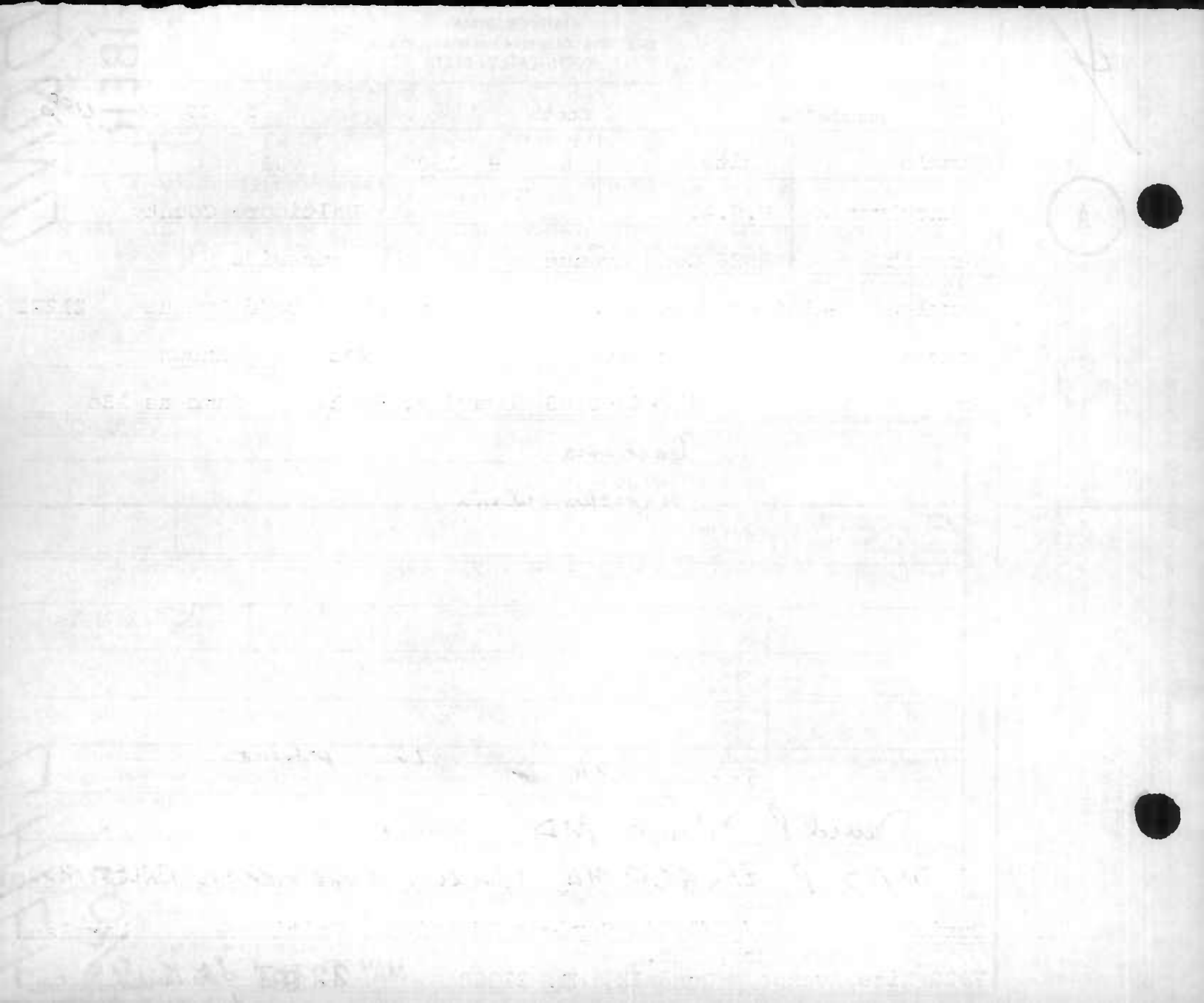
|  |  |                        |  |  |  |  |  |
|--|--|------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                       |  | 23b. DATE<br>5/22/1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc., ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222 |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984           |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 6 0

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Vincenta Bova</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 13 1984</b>  |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 12 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Argentina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>531 S. 45th Street</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>A &amp; G Clothier</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Dundalk</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 13e. STREET ADDRESS / ZIP CODE<br><b>531 S. 45th Street 21224</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Conti</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa Pimia Conti</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-14-3876</b>  |  | 17. INFIRMITY ADDRESS<br><b>Mrs. Rose Kelly 21133<br/>3802 Marriottsville Road Randallstown Maryland</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Extensive atherosclerotic cardiac vascular disease.</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Coronary Artery Failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>C.I.D.</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>4/8</b> , 19 <b>83</b> , to <b>5/13</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Joseph B. Roberts</b><br>REG. REGISTRAR'S NAME (TYPE OR PRINT)  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/14/84</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>05-16-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Rd. Randallstown, MD 21133</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Randall</b> |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10.35

## Analysis

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 6 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                                |   |   |  |   |       |  |
|--|--|--|---|---|--------------------------------|---|---|--|---|-------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EMILY C BOWEN                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 10 84                |   |                                | 2b. HOUR<br>2 <sup>10</sup> AM  |   |  |   |       |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-29-89  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |   |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Scotland                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                 |   |  |   |       |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |   |   |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>unknown |   |       |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>--   |   | 13c. CITY OR TOWN<br>Baltimore |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>802 E. Coldspring Lane 21212 |       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>unknown                          |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown  |                                |   |   |  |   |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-- |   | 17. INFORMANT<br>Baltimore     |   | ADDRESS<br>MD   |  |   |       |  |
|  |  |  |   | 213-10-0535D  |                                | Evelyn Bennett  |   | 3939 Penhurst Ave.                           |   | 21215 |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

4280

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Congestive Heart Failure → RENAL

DUE TO, OR AS A CONSEQUENCE OF

(c) FAILURE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)

## MEDICAL CERTIFICATION

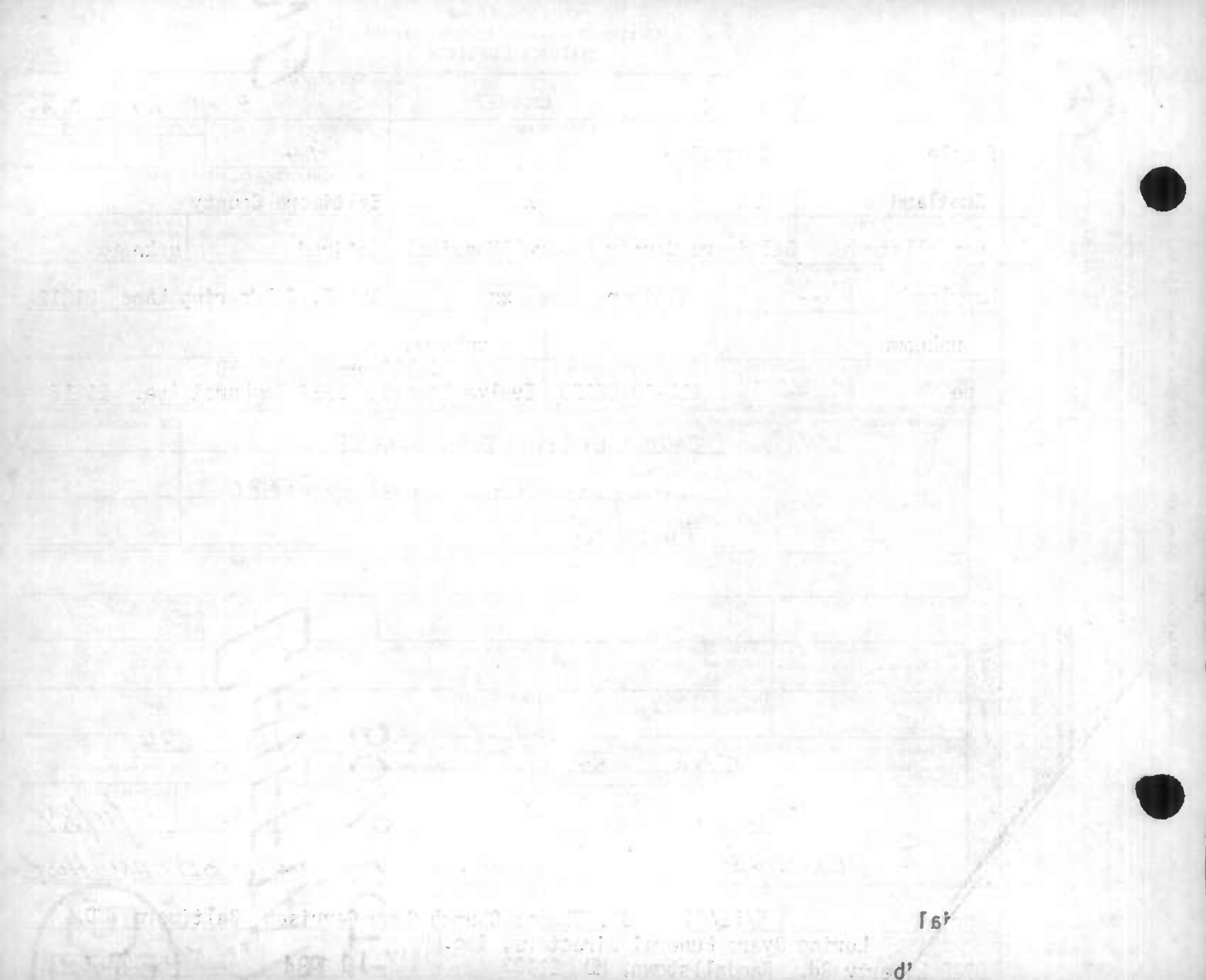
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/5/84</u> to <u>5/10/84</u> , that (I) (we) lost<br>saw the deceased alive on <u>5/10/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Loring Byers</u>   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5/10/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. DEBESTRE  |  |  |  | 22e. ADDRESS<br>BALTIMORE COUNTY GENERAL HOSP.   |  |  |  |

|  |  |                      |  |   |  |   |  |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial               |  | 23b. DATE<br>5/12/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Thomas Church Cem |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Garrison Baltimore MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Loring Byers Funeral Directors, Inc. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 11 1984                |  | 25b. REGISTRAR'S SIGNATURE<br><u>L. Davidson-Randall</u>            |  |
| 8728 Liberty Rd. Randallstown, MD 21133                              |  |                      |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

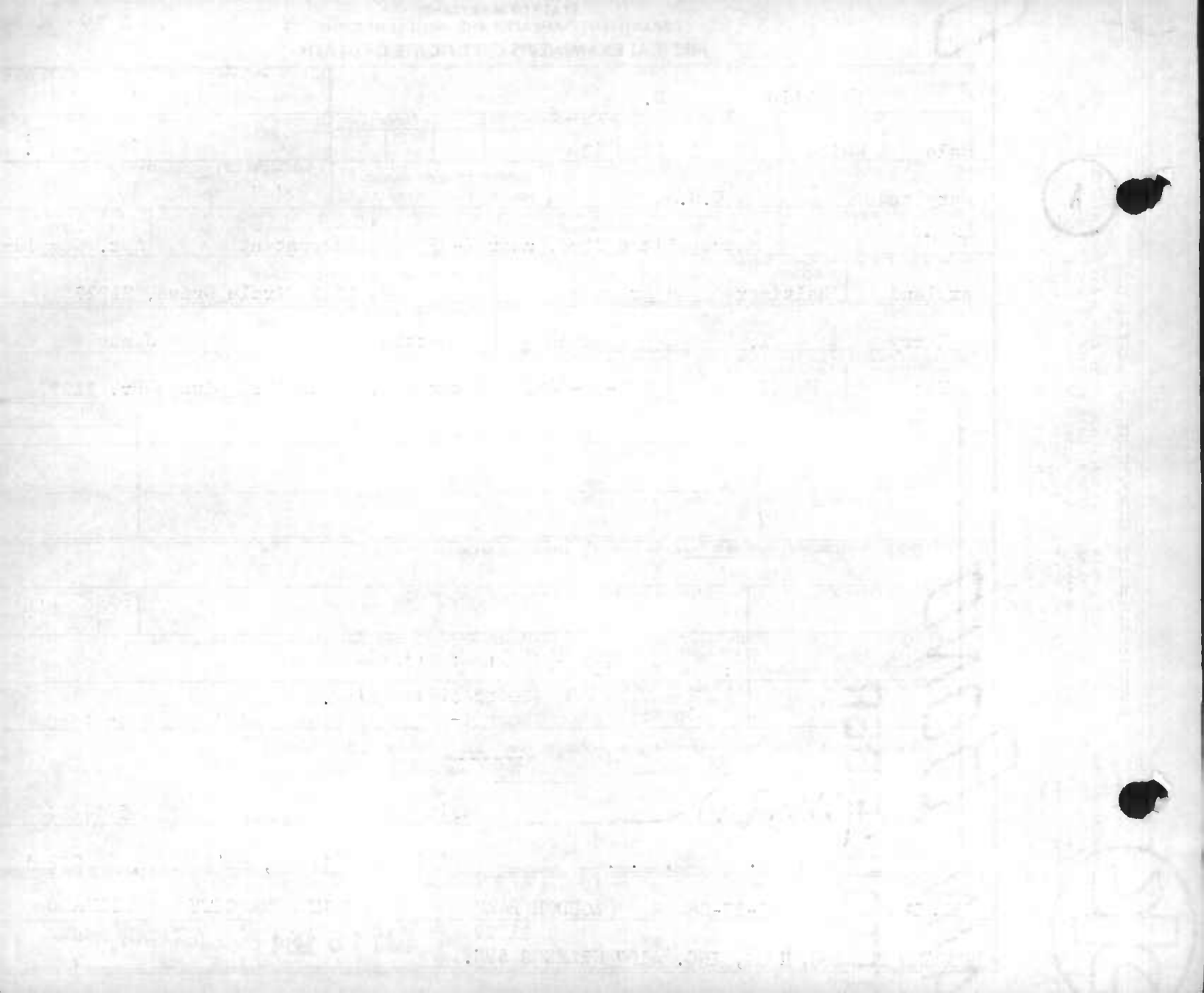


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |   |   |                               |  |  |   |                      | REG. NO.   |  |
|--|----------------------|--|---|---|-------------------------------|--|--|---|----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Franklin D. Bowen</b>   |                      |  |   |   |                               |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>5 13 1984</b> |   | 2b. HOUR <b>2:10</b> |  |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>07 21 21</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>62</b> YRS. | IF UNDER 1 YR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5 13 1984</b>  | 2d. HOUR <b>2:10</b>   |   |                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.   |  |   |                      |  |  |
| 10. CITY OR TOWN OF DEATH <b>Arbutus</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Metropolitan Blvd. near I-95</b> |   |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Apt. Complex</b>                     |                      |  |  |
| 13a. STATE <b>Maryland</b>   |                      | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Arbutus</b>  |                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 13e. STREET ADDRESS <b>1211 Circle Drive, 21227</b>                       |                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Harry I. Bowen</b>   |                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Mattie Jones</b>   |                               |  |  |   |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |                      | (IF YES, GIVE WAR OR DATES) <b>WW II</b>   |   | 16b. SOCIAL SECURITY NO. <b>201-03-6628</b>   |                               | 17. INFORMANT ADDRESS <b>Cathryn M. Bowen 1211 Circle Dr, 21227</b>  |  |   |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9551</b> IMMEDIATE CAUSE (a) <b>Shotgun wound of chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                      |  |   |   |                               |  |  |   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                      |  |   |   |                               |  |  |   |                      |  |  |
| 19a. DATE OF OPERATION   |                      |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                               |  |  |   |                      | 20. AUTOPSY? <b>body only</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |  |   | 21b. TIME OF INJURY<br>HOUR <b>2:00</b> P.M. MONTH DAY YEAR <b>5 13 1984</b>  |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted</b>              |  |   |                      |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway</b>  |                               | 21f. LOCATION<br><b>Metropolitan Blvd. near I-95</b> CITY OR TOWN COUNTY STATE <b>Arbutus Baltimore Maryland</b> |  |   |                      |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                      |  |   |   |                               |  |  |   |                      |  |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>   |                      |  |   | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER  |                               |  |  | DATE SIGNED <b>5/14/84</b>  |                      |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |                      |  |   | ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>   |                               |  |  |   |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                      | 23b. DATE <b>05-17-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>   |                               |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b> |                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE. 21229</b>  |                      |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1984</b>  |                               | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Hendall</b>  |  |   |                      |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |                                    |   |  |
|--|--|---|------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edward R. Braham</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 3 1984</b>   |                                    | 2b. HOUR<br><b>10<sup>35</sup> P.M.</b>   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 14th, 1896</b>  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Wis.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. County</b> MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(DO NOT INCLUDE FACTORY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b>                     |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MAIN SOURCE OF INCOME)<br><b>Catholic Priest</b>      |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Towson</b> | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Braham</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Zahorek</b>   |                                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-38-6178</b>  |                                    | 17. INFORMANT ADDRESS<br><b>Mr. David G. Mulligan-211 Blenheim Rd. 21212</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHF (Congestive Heart Failure)</b><br><b>4/49</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>due to Ischemic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                                    |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>None</b>  |  |   |                                    |   |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>  |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |                                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> , 19 <b>80</b> , to <b>5/3</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |                                    |   |  |
| 22b. SIGNATURE<br><b>Dr. Eddie Nkhudga</b>   |  | DEGREE<br><b>Stella Maris Hospice</b>   |                                    | 22c. DATE SIGNED<br><b>5/3/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><b>Duloney Valley Rd.</b>   |                                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/7/84</b>  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>  |  | 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home 6500 York Rd. Balto. 21212</b>   |                                    |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>   |                                    |   |  |

BP \_\_\_\_\_



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to decipher but appear to include:]*

*... of ...*  
*... and ...*  
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*... from ...*  
*... at ...*  
*... on ...*  
*... in ...*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | 8 4 1 2 2 6 4                                  |           |             |                   |
|---|--|--|--|---|--|---|--|---|--|--|-----------|-------------|-------------------|
| 1- FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |   |  |   |  |  |           |             |                   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST<br>HAZELTON  |  | MIDDLE<br>A.  |  | LAST<br>BRANNOCK  |  | 2a. DATE OF DEATH   |  | MONTH<br>05                                    | DAY<br>03 | YEAR<br>'84 | 2b. HOUR<br>9:44A |
| 3. SEX<br>Male  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 12, 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. UNDER 24 HRS.<br>HOURS MIN.                 |           |             |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Cambridge, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                                   |  |   |  |  |           |             |                   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Naval  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Architect |           |             |                   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>24 Indian Lane  |  | 21210  |           |             |                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bayly Brannock  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Roberta Colburn   |  |   |  |   |  |   |  |  |           |             |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW 1   |  | 17. INFORMANT<br>ADDRESS<br>Dorothy Poehlitz 2479 Woodcroft Rd. Bal. Md 34  |  |   |  |   |  |  |           |             |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>4049 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIO RENAL VASCULAR DISEASE IN PROCESS<br>OF COMPLETING PROSTATIC OPERATION (TRANS URETHRAL RESECTION OF PROSTATE<br>DUE TO, OR AS A CONSEQUENCE OF (c) RESECTION OF PROSTATE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |   |  |  |           |             |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |   |  |   |  |  |           |             |                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>URINARY RETENTION 20 TO ENLARGED PROSTATE  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |           |             |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |  |           |             |                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |           |             |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2 19 84 to 5/3 19 84, that (I) (we) last saw the deceased alive on 5/3 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |  |           |             |                   |
| 22b. SIGNATURE<br>J. Ricely   |  | DEGREE<br>D.O.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>5/3/84  |  |  |           |             |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES C. RICELY, D.O.  |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES STREET 21204  |  |   |  |   |  |   |  |  |           |             |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>May 7, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville Balto. Co. Md.                          |  |   |  |  |           |             |                   |
| 24. FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home 6500 York Rd. Bal. Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 7 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Davidson-Randall   |  |   |  |   |  |  |           |             |                   |

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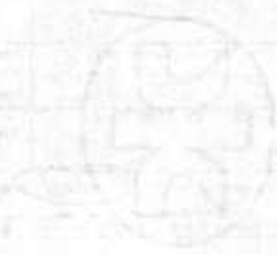
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

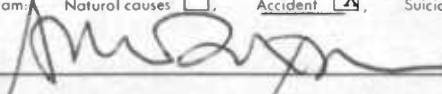

|  |  |   |                                      |   |  |
|--|--|---|--------------------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH   |                                      | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |                                      | 2b. HOUR  |  |
| FANNY BRECHER  |  | 5 31 84   |                                      | 12 <sup>25</sup> P.M.   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)      | IF UNDER 1 YEAR   |  |
| Female   | CAUCASIAN  | 11 13 95  | 88                                   | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| AUSTRIA  | US   |   | BALTIMORE County MD                  |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY    |   |  |
| PIKESVILLE   | Pikesville NURSING HOME  | House wife  | AT HOME                              |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |   |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13e. STREET ADDRESS                  |   |  |
| MD   | BALTO.   | BALTIMORE   | 7507 SLADE AVE. 21208                |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |                                      | 16. SOCIAL SECURITY NO.   |  |
| HERMAN CHAIM HERMAN  |  | HELD  |                                      | 219-32-0362   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)   |  | 17. INFORMANT   |                                      | ADDRESS   |  |
| NO   |  | Dr Herman Brecher   |                                      | 6 PICASSO CT Pikesville, MD   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |                                      |   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |   |                                      |   |  |
| IMMEDIATE CAUSE (a) Respiratory Arrest   |  |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Disease   |  |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Systemic Emboli  |  |   |                                      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Congestive heart failure  |  |   |                                      |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/22, 19 84, to 5/31, 19 84, that (I) (we) last saw the deceased alive on 5/30, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                                      |   |  |
| 22b. SIGNATURE   |  | DEGREE  |                                      | 22c. DATE SIGNED  |  |
| STEVEN B. STEINBERG MD   |  | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>    |                                      | 5/31/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |                                      |   |  |
| STEVEN STEINBERG   |  | 3502 CROYDON RD BALTIMORE MD  |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| BURIAL   |  | JUNE 1, 1984  |                                      | SHAAREI TFILOH  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |                                      | 25b. REGISTRAR'S SIGNATURE  |  |
| SOL LEVINSON   |  | JUN 6 1984  |                                      | John Davidson   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |   |  |   |  |   |   |  | REG. NO. |  |
|--|----------------------|--|---|--|---|--|---|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWARD LEE BREWER, SR.</b>  |                      |  |   |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>5</b> DAY <b>19</b> YEAR <b>1984</b>        |   | 2b. HOUR <b>5:50</b> P.M.   |  |          |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>May</b> DAY <b>15</b> YEAR <b>1938</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.  | IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>   | 2c. DATE PRONOUNCED DEAD <b>5</b> MONTH <b>19</b> DAY <b>1984</b>  |   | 2d. HOUR <b>5:50</b> P.M.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.   |   |   |  |          |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Molder</b>                                      |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>                                      |  |          |  |
| 13a. STATE <b>Maryland</b>   |                      | 13b. COUNTY <b>Harford</b>   |   | 13c. CITY OR TOWN <b>Darlington</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   | 13e. STREET ADDRESS <b>4029 Patrick Road 21034</b>                                  |  |          |  |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b>Lee</b> LAST <b>Brewer</b>  |                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Encilee</b> MIDDLE <b>--</b> LAST <b>Blevins</b>  |   |  |   |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>214-34-3872</b>  |   | 17. INFORMANT <b>E. Lee Brewer, Jr.</b> ADDRESS <b>Bel Air, Md 21014</b><br><b>2650 Conowingo Rd</b>   |   |  |   |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br><b>8122</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |                      |  |   |  |   |  |   |   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                      |  |   |  |   |  |   |   |  |          |  |
| 19a. DATE OF OPERATION   |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |  |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |  | 21b. TIME OF INJURY<br>HOUR <b>5</b> P.M. MONTH <b>5</b> DAY <b>19</b> YEAR <b>84</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Operator of motorcycle/van collision.</b>    |  |   |   |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>               |  | 21f. LOCATION<br>STREET <b>Rt. 19, Conowingo Rd., Bel Air,</b> CITY OR TOWN <b>Harford</b> COUNTY <b>Md.</b> STATE <b>Md.</b> |  |   |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |  |   |  |   |  |   |   |  |          |  |
| ACTUAL SIGNATURE    |                      |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER                                     |  |   |  | DATE SIGNED <b>5-20-84</b>  |   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |   |  |   |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>May 23, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens, Bel Air</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Harford</b> COUNTY <b>Md.</b> STATE <b>Md.</b> |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Howard K. McComas III, Abingdon, Md.</b> ADDRESS <b>21009</b>  |                      |  |   | 25. DATE REC'D. BY REGISTRAR <b>22 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE  |   |   |  |          |  |



ENCLOSURE

100-100000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |   |   |                                |   |  |   |  | REG. NO. |  |
|---|------------------|---|---|---|--------------------------------|---|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BRIGHT, KEVIN L BRIGHT</b>   |                  |   |   |   |                                | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>May 19 1984</b>   |  | 2b. HOUR <b>3:48 PM</b>   |  |          |  |
| 3. SEX <b>M</b>   | 4. RACE <b>B</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>05-05-65</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>18</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD <b>May 19 1984</b>   |  | 2d. HOUR <b>3:48 PM</b>   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |
| 13a. STATE<br><b>Maryland</b>   |                  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2554 Garrett Avenue 21218</b>                           |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Bright</b>   |                  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Murial Rawlings</b>   |                                |   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>   |                  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Arthur E. Hodge 2554 Garrett Avenue</b>  |                                |   |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>9550 IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which give rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Bullet Wound of Heart causing</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe Cerebral Ischemia</b>                   |                  |   |   |   |                                |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:<br><b>25 Days</b><br><b>19 Days</b> |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |   |   |   |                                |   |  |   |  |          |  |
| 19a. DATE OF OPERATION<br><b>5/1/84</b>   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Repair of 2 Bullet Wounds</b>   |   |   |                                |   |  |   |  |          |  |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21a. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>P.M. <b>May 1 1984</b>  |   | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Self-Inflicted Pistol Wound</b>   |                                |   |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2208 Penn Ave Baltimore Md</b>  |                                |   |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |   |   |                                |   |  |   |  |          |  |
| ACTUAL SIGNATURE<br><b>Charles Choudhary</b>  |                  | TITLE (DIRECTOR)<br><b>Deputy</b>   |   | MEDICAL EXAMINER  |                                |   |  | DATE SIGNED<br><b>5/19/84</b>   |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |                  | ADDRESS   |   |   |                                |   |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |                  | 23b. DATE<br><b>5/25/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Eternal Hope, Baltimore Co, Md.</b>  |                                |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |                  | ADDRESS<br><b>1101 E North Avenue</b>   |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 22 1984</b>  |                                | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                      |  |   |  |          |  |

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BOND



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rose Mary BROKKE                     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 22, 1984 |   |  | 2b. HOUR<br>6:15PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 17 1923   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>School Teacher              |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Doyas                        |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Stenzy   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  | 16b. SOCIAL SECURITY NO.<br>WW II<br>216-16-8611  |   | 17. INFORMANT<br>ADDRESS<br>Olaf Brokke Same As 13e   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4148 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Severe Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Ischemic Cardiomyopathy

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 22, 1984, to May 22, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 22, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>George Karkar   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5/22/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George Karkar, MD  |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |  |   |  |

|  |  |                      |  |   |  |   |  |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>5/25/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Ht. Of Jesus |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk Balto. Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222 |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 29 1984              |  | 25b. REGISTRAR'S SIGNATURE<br>Felia Tardis                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VERNON L. BROSIUS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-31-84</b> |   |  | 2b. HOUR<br><b>1:40 P.M.</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 18 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Towson</b> MD.                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson, MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-employed</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>235 Blenheim Road 21212</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Brosius</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Walters</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218 14 3071</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. H. Wilson Spies 3602 Howard Park Ave. 21204</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>9120 Aspiration 2° to hypoxia</b><br>IMMEDIATE CAUSE (a) <b>Aspiration 2° to hypoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Asphyxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5 13 19 84</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/31</b> , 19 <b>84</b> , to <b>5/31</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>B.K. Jorloff, MD</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>6/1/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jorloff</b>  |  |  |   | 22e. ADDRESS<br><b>7600 Osler Dr</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6/5/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

or  $\|f\|_{\infty} = \max_{1 \leq i \leq n} |f(x_i)|$

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before removal of the body.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vernie D. Browning</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5/18/84</b>                     |   |   | 2b. HOUR<br><b>3:05 A</b> M  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 17, 1901</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian-Randallstown</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Mechanic</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Delivery of Balt</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>                                  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>227 Church Lane 21208</b>             |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Benjamin Browning</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary (Unknown)</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No --</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>215-03-2554</b>                         |   | 17. INFORMANT <b>Sykesville, ADDRESS MD 21784</b><br><b>Mr. Paul Browning 7710 Carter Rd.</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/17/84</b> 19 <b>84</b> to <b>5/17/84</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/17/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>WILFSON</b>   |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/18/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILFSON</b>  |  |   | 22e. ADDRESS<br><b>PO 66, Garrison Md 21055</b>                        |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>5/21/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>   |  |  |  |  |
| 8728 Liberty Rd. Randallstown, MD 21133  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |  |  |  |

BP



*Handwritten text, possibly a signature or name, appearing in the center of the page.*

*Handwritten text, possibly a date or reference number, appearing in the lower middle section.*

*Handwritten text, possibly a date or reference number, appearing in the lower right section.*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
|--|---------|------------------|---|----------------|------------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | FIRST MIDDLE LAST   |                |                  | 2a. DATE KNOWN OF DEATH  |  |  | MONTH DAY YEAR  |  |  | 2b. HOUR                                     |  |  |
| CHARLES THOMAS BRUCE, IV   |         |                  |   |                |                  | 5-30-84  |  |  |   |  |  | 10:59  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD   |  |  | MONTH DAY YEAR  |  |  | 2d. HOUR                                     |  |  |
| M  | B       | 9 26 79          | 4 YRS.  |                |                  | 5-30-84  |  |  |   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| MD   |         |                  | USA   |                |                  |  |  |  | Baltimore County  |  |  | MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Catonsville  |         |                  | 63 Winters Lane   |                |                  |  |  |  |   |  |  |  |  |  |
| 13a. STATE   |         |                  | 13b. COUNTY   |                |                  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS                          |  |  |
| MD   |         |                  | Baltimore   |                |                  | Catonsville  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 63 Winters Lane 21228                        |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME  |                |                  |  |  |  |   |  |  |  |  |  |
| Charles T. Bruce III   |         |                  | Mary Gaither  |                |                  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |                  | 16b. SOCIAL SECURITY NO.  |                |                  | 17. INFORMANT  |  |  | ADDRESS   |  |  |  |  |  |
| No   |         |                  | N/A   |                |                  | Annie Gaither  |  |  | 42 Bloomingdale Ave   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>8902 IMMEDIATE CAUSE (a) Smoke and soot inhalation<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |                  |   |                |                  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                |                  |  |  |  | 20. AUTOPSY?  |  |  |  |  |  |
|  |         |                  |   |                |                  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |  |  |  |
|  |         |                  | 10:45 PM 5-30-84  |                |                  | caught in a housefire  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                |                  | 21f. LOCATION  |  |  |   |  |  |  |  |  |
|  |         |                  | home  |                |                  | 63 Winters Lane Catonsville, Maryland STATE  |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE   |         |                  | TITLE (SPECIFY)   |                |                  |  |  |  | DATE SIGNED   |  |  |  |  |  |
| Margarita A. Korell, M.D.  |         |                  | Assistant MEDICAL EXAMINER  |                |                  |  |  |  | 5-31-84   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                  | ADDRESS   |                |                  |  |  |  |   |  |  |  |  |  |
| Margarita A. Korell, M.D.  |         |                  | 111 Penn Street   |                |                  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  | 23b. DATE   |                |                  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |  |  |  |
| Burial   |         |                  | 6/4/84  |                |                  | Dulaney Valley Cem.  |  |  | Towson COUNTY STATE MD  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |         |                  |   |                |                  |  |  |  |   |  |  |  |  |  |
| NAME   |         |                  | ADDRESS   |                |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |  |  |  |  |
| W.C. March F/H, Inc.   |         |                  | 1101 E. North   |                |                  |  |  |  | JUN 4 1984 Julia Davidson-Randall                                   |  |  |  |  |  |

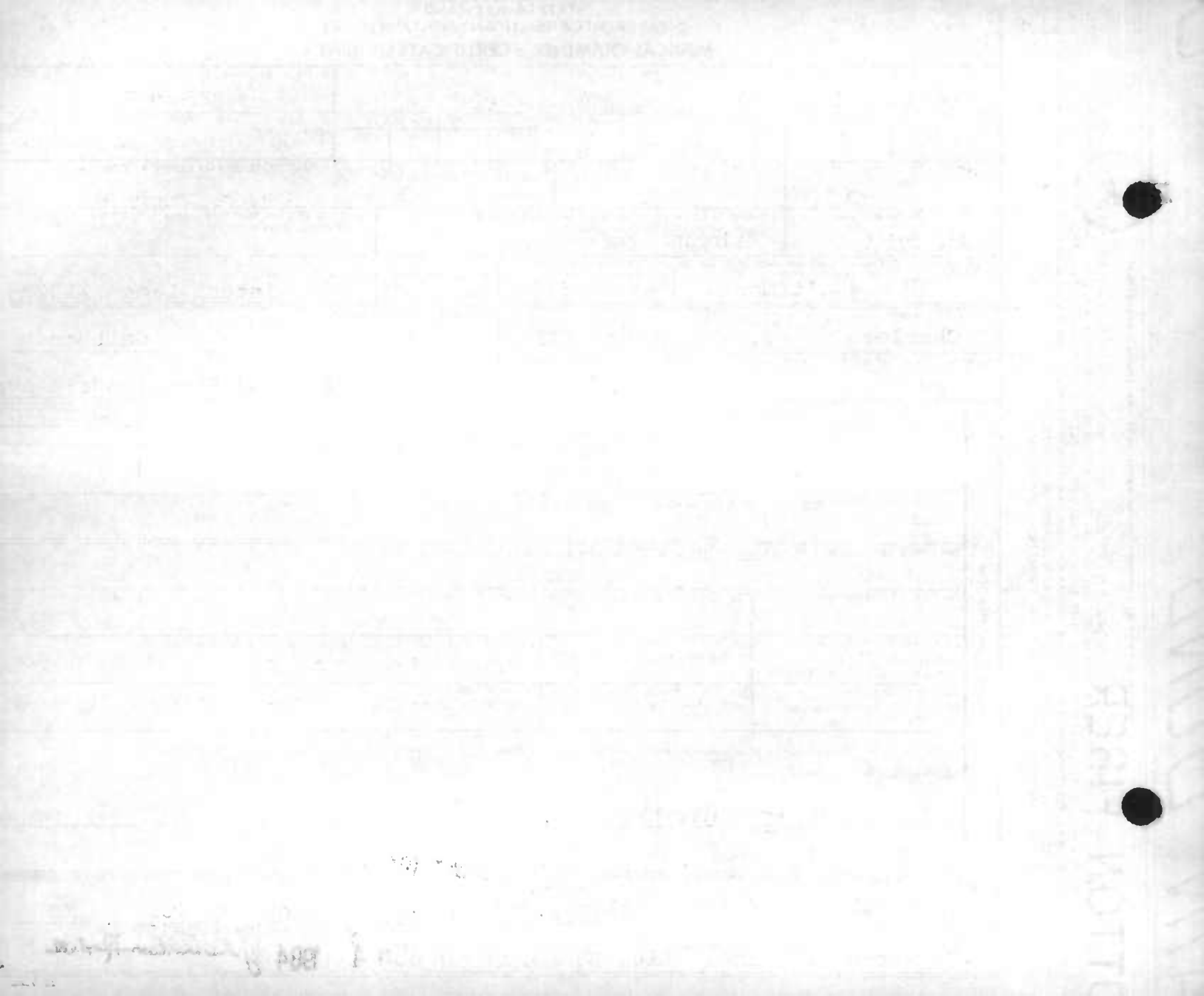
JUL 1 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITHIN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                     |   |  |  |   |   |  |  |  | REG. NO.  |   |
|--|---------------------|---|--|--|---|---|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Tralissa (RELICIA) ANN BRUCE</b>  |                     |   |  |  |   |   |  |  |  | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5-30-84</b> 19 |   |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>B</b> | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 31 78</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>6 YRS.</b>   |   | 7c. DATE PRONOUNCED DEAD<br><b>5-30-84</b> 19   |  | 2d. HOUR PM<br><b>10:58</b>                    |  |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD  |  |  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>63 Winters Lane</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |   |   |
| 13a. STATE<br><b>MD</b>  |                     |   |  |  |   |   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   |
| 13c. CITY OR TOWN<br><b>Catonsville</b>  |                     |   |  |  |   |   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |   |
| 13e. STREET ADDRESS<br><b>63 Winters Lane 21228</b>  |                     |   |  |  |   |   |  |  |  |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles T. Bruce III</b>   |                     |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Gaither</b> |   |  |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |                     |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b> |  | 17. INFORMANT<br><b>Annie Gaither</b>                             |   |  | ADDRESS<br><b>42 Bloomingdale Ave</b>          |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8902</b> IMMEDIATE CAUSE (a) <b>Smoke and soot inhalation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                     |   |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                     |   |  |  |   |   |  |  |  |   |   |
| 19a. DATE OF OPERATION   |                     |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     |   |  | 21b. TIME OF INJURY HOUR MONTH DAY YEAR<br><b>10:45 PM 5-30-84</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>caught in a housefire</b> |  |  |  |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                     |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |   | 21f. LOCATION<br><b>63 Winters Lane Catonsville, Maryland</b> STATE   |  |  |  |   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |   |  |  |   |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |                     |   |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |   |   |  | MEDICAL EXAMINER<br><b>DATE SIGNED 5-31-84</b> |  |   |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                     |   |  | ADDRESS<br><b>111 Penn Street</b>  |   |   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                     |   | 23b. DATE<br><b>6/4/84</b>             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>  |   |  | 23d. LOCATION CITY OR TOWN<br><b>Towson</b>    |  |   | COUNTY<br><b>MD</b>                                 |
| 24. FUNERAL DIRECTOR NAME<br><b>W.C. March F/H, Inc.</b>   |                     |   |  |  |   | ADDRESS<br><b>1101 E. North</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1984</b> |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Anderson</i> |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Postmortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anthony P. Bruno</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 20, 1984</b>                                      |  | 2b. HOUR<br><b>4:38 p.m.</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 26, 1901</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sicily</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tailor</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nunzio Bruno</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joan</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-12-9586A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Miss Joan A. Bruno same as # 13</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Pulmonary infarct, right</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                               |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1984</b> , to <b>May 20, 1984</b> , that (I) (we) last saw the deceased alive on <b>May 20, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><i>R. Breitenecker</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>May 21, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rudiger Breitenecker, M.D.</b>  |  | 22e. ADDRESS<br><b>6701 N. Charles St. Towson MD 21204</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>5/22/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>   |  |  |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                      |  |  |

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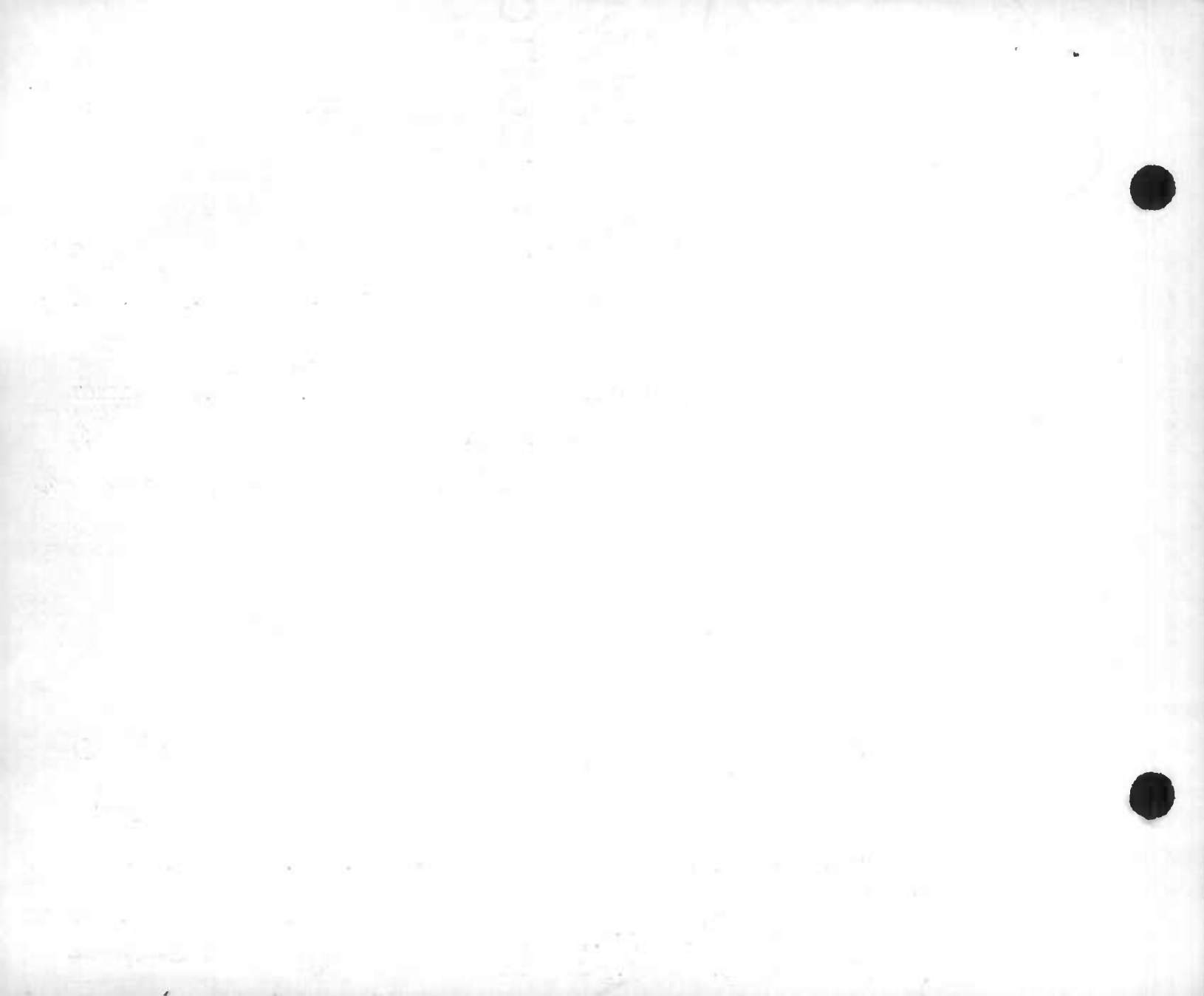
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 7 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

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|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MAX BUCHDAHL</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 5 1984</b>                                     |   | 2b. HOUR A.<br><b>3:04 M</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>OCT. 24, 1910</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>73</b>   |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8404 MERRYMOUNT DR.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WHOLESALE</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY<br><b>NEW YORK</b>  |   |   | 13b. CITY OR TOWN<br><b>NEW YORK</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>#10032<br/>715 W. 170TH ST., APT. 22 999</b>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>GUSTAV BUCHDAHL</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ROSA BLOCH</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>055-12-0174</b>  | 17. INFORMANT <b>RABBI GUSTAV BUCHDAHL</b><br><b>8404 MERRYMOUNT DR. BALTO., MD 21207</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>Liver failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the colon with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 months</b>  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)            |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>4/1</b> , 19 <b>84</b> , to <b>5/5</b> , 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>5/4</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Bernard R. Shochet, M.D.</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>5/5/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD SHOCHET, M.D.</b>  |   | 22e. ADDRESS<br><b>6804 PARK HTS. AVE. BALTO., MD</b>   |   |   |  |
| 23a. BURIAL OR REMOVAL<br>(SEE ITEM 18)<br><b>BURIAL</b>   | 23b. DATE<br><b>MAY 6, 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR PARK</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WESTWOOD NEW JERSEY</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>  |   |  |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>J. Davidson</i>  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 7 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |   |   |  |
|--|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BEATRICE M. BUCK</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 19, 1984</b>             |   |   | 2b. HOUR<br><b>6:10A M</b>   |   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 11 1911</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 13a. STATE<br><b>MD.</b>   |  |  | 13b. CITY OR TOWN<br><b>HARFORD</b>                                    |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>1507 HONEYSUCKLE DR. 21014</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BERNARD BUBERL</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOUISE KOUBEK</b>  |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-24-9001</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>HARRY BUCK JR. (SON) 507 HONEYSUCKLE DR. BELAIR MD.</b>          |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br><b>4151 IMMEDIATE CAUSE (a) MULTIPLE PULMONARY THROMBOEMBOLI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAY 15</b> , 19 <b>84</b> , to <b>MAY 19</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MAY 19</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we did not) view the body after death. |  |  |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>JEFFREY ZLOTNICK</b>  |  |  | DEGREE   |   |   | 22c. DATE SIGNED   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEFFREY ZLOTNICK M.D.</b>  |  |  | 22e. ADDRESS<br><b>9000 FRANKLIN SQUARE DRIVE 21237</b>                |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>5/22/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>  |   |  |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><b>SCHEMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Hendall</b>               |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
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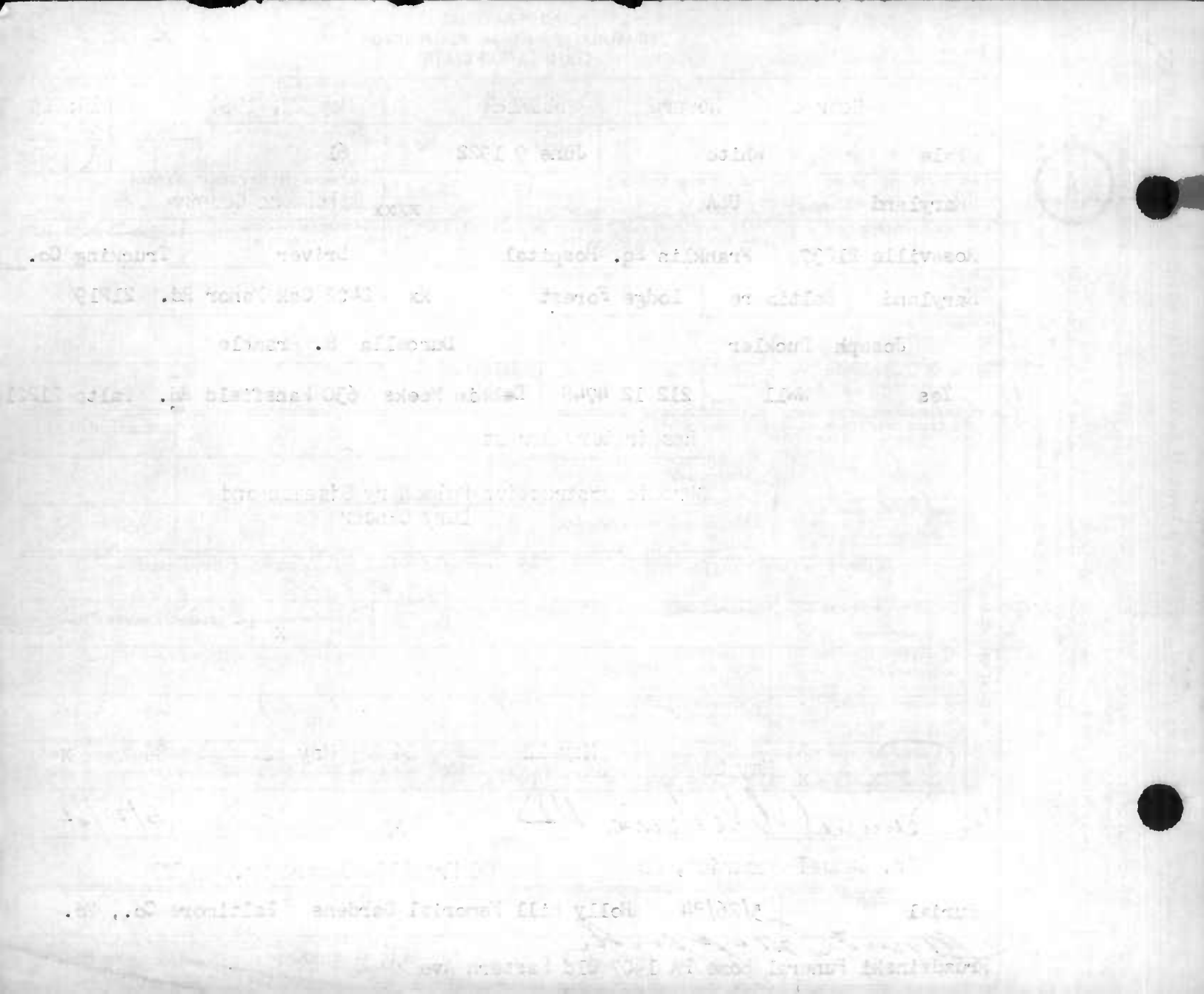
REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George Howard BUCKLER</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 22, 1984</b>                                      |  | 2b. HOUR<br><b>10:42p<sub>m</sub></b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 9 1922</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking Co.</b>                             |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Lodge Forest</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS & ZIP CODE<br><b>2402 Oak Manor Rd. 21219</b>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Buckler</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Durcella E. Bramble</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WWII 212 12 4748</b>   |   | 17. INFORMANT ADDRESS<br><b>Debbie Meeks 630 Mansfield Rd. Balto 21221</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>Respiratory Arrest</b><br>IMMEDIATE CAUSE (a)<br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Obstructive Pulmonary Disease and Lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 21g. I certify that (I) (this hospital) attended the deceased from <b>May 22</b> , 19 <b>84</b> , to <b>May 22</b> , 19 <b>84</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>May 22</b> , 19 <b>84</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> not view the body after death. |   |   |   |  |  |
| 22a. SIGNATURE<br><i>Samuel Westrick MD</i>   |   | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Samuel Westrick, MD</b>   |   | 22c. DATE SIGNED<br><b>5/22/84</b>   |  |
| 22d. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |   | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |   | 23b. DATE<br><b>5/26/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Memorial Gardens</b>             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1984</b>   |   |  |  |
| 23f. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   | 23g. REGISTRAR'S NAME<br><b>John Davidson-Hendall</b>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 7 7

|  |  |   |  |
|--|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DONALD F. BUECKER SR.</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MAY 28, 1984</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 2b. HOUR<br><b>5:45AM</b>   |  |
| 4. RACE<br><b>WHITE</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 2 1930</b>   |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>MIDDLE RIVER</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3412 HONEYSUCKLE LANE</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DISABLED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  |
| 13c. CITY OR TOWN<br><b>MIDDLE RIVER</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET NIMMO</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-24-4236</b>  |  |
| 17. INFORMATION<br><b>HELEN BUECKER SAMS</b>   |  | ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Coronary pulmonary Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Probably due to Myocardial Infarction</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                              |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.   |  |   |  |
| 22b. SIGNATURE<br><b>Augustus O'Hemengs, M.D., MPH</b>   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AUGUSTUS OHEMENG, M.D., MPH</b>  |  | 22e. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAY 31, 1984</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEMORIAL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. G. CONNELLY</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1984</b>   |  |
| ADDRESS<br><b>300 MALE AVE</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. Davidson-Randall</b>   |  |

MEDICAL CERTIFICATION



2014 COLLECTION

1/1/14



Handwritten notes and a table at the top of the page. The table has several columns and rows, with some cells containing numbers and others containing text. The handwriting is somewhat faded and difficult to read.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   | 8 4 1 2 2 7 8  |   |   |  |   |
|---|--|---|---|---|--|---|---|--|---|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO.   |   |   |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Eva G. Buffington   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 1, 1984  |   |   |  | 2b. HOUR<br>1:40A.M.  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>August 21, 1893  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS   |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Parkville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Perring Parkway Nursing |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                      |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>--   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>1477 Roland Heights Ave. 21211  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas William Lee Sakers  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura Lee Harrison   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>213 26 8825  |   | 17. INFORMANT ADDRESS<br>Joan Bowen 1477 Roland Heights Ave 21211 |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cong Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Card. Dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>4292 |  |   |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 weeks<br>10 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |   |   |   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |   |   |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10/</u> 19 <u>44</u> to <u>May 1</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>April 30</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |   |   |  |   |   |  |   |
| 22b. SIGNATURE<br>Leonard Wallenstein   |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>5/3/84  |  |   |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Leonard Wallenstein  |  |   |   |   | 23b. ADDRESS<br>711 W 40 <sup>th</sup> St  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5/4/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                  |   |  |   |
| 24. FUNERAL DIRECTOR NAME<br>Burgee Funeral Home 3631 Falls Road 21211  |  |   |   |   |  | 25a. DATE REC'D BY REGISTRAR<br>MAY 7 1984  |   |  |   |
|   |  |   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell  |   |  |   |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |   |  |
|--|--|--|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Minnie E. Bull</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 14, 1984</b> |  |  | 2b. HOUR<br><b>M</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 29, 1886</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>97</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Stoneleigh</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Armcast Nursing Home</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b> |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Stoneleigh</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Allison</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sara Margaret Bounds</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219 01 4267D</b>   |   | 17. INFORMANT<br><b>E. Ruth Bull</b>   |  | ADDRESS<br><b>Same</b>  |  |

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

4292 IMMEDIATE CAUSE (a) Arterio-sclerotic cardio-vascular disease  
DUE TO, OR AS A CONSEQUENCE OF  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-25, 19 64</u> to <u>5-14, 19 84</u> , that (I) (we) lost<br>saw the deceased alive on <u>Apr 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Reuben Hoffman, M.D.</u>  |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>5-15-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Reuben Hoffman</b>   |  |  |  | 22e. ADDRESS<br><b>846 W. 36th Street, Baltimore, Md. 21211</b>                |  |   |  |

|  |  |                                 |  |   |  |  |  |
|--|--|---------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>                          |  | 23b. DATE<br><b>17 May 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burgee Funeral Home, 3631 Falls Road, 21211</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1984</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>              |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothea B. Burgess  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5/27/84                         |   |  | 2b. HOUR<br>1:00 PM  |  |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 22 05  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Catonsville MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Inglenook N.H. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B+O. R.R.   |  |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>21228<br>6114 Edmondson Ave   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel B. Burgess   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blouner UNK.   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>205-05-7451   |  | 17. INFORMANT<br>ADDRESS<br>Joanne Myerson Inglenook N.H.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple strokes<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Yrs. |  |   |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27/84 to 5/27/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (If no) (If did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>J McHILLIPS   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5/27/84  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   |  |   |  | 23b. DATE<br>MAY 30, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREENMONUT CEMETERY  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT RAMSEY   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1984  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| 436 WESTSHIRE DRIVE 21228   |  |   |  |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHIEFLIN

20% COLLOID



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 8 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                                       |  |   |                     |  |
|---|--|--|---|--|---------------------------------------|--|---|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BABY BOY BURKE</b>                     |  |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>29</b> YEAR <b>84</b>                        |  |                                       | 2b. HOUR<br><b>6:20</b> A M  |   |                     |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W.</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>29</b> YEAR <b>84</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>2</b> MONTHS <b>2</b> DAYS <b>2</b> |   |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. County</b> MD.                |   |                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>n/a</b>   |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>n/a</b>                                |   |                     |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>6305 Old Washington Rd</b>               |  |  | 13f. ZIP CODE<br><b>21227</b>   |  |                                       |  |   |                     |  |
| 14. FATHER'S NAME<br>FIRST <b>David</b> MIDDLE <b>Burke</b> LAST <b>Burke</b> |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Kathleen</b> MIDDLE <b>Turos</b> LAST <b>Turos</b> |  |                                       |  |   |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>-</b> |  |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>  |  | 17. INFORMANT<br><b>-</b>             |  |   | ADDRESS<br><b>-</b> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:7650 IMMEDIATE CAUSE (a) **Non-viability**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

## MEDICAL CERTIFICATION

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5-29</b> , 19 <b>84</b> , to <b>5-29</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5-29</b> , 19 <b>84</b> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>S. A. Linnar</b>   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>5-29-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SINNAR, Z. A.</b>   |  |   |  | 22e. ADDRESS<br><b>St. Joseph Hospital</b>   |  |   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Hosp Disp</b>  |  | 23b. DATE<br><b>5-29-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>St Joseph Hospital</b> ADDRESS <b>7620 York Road towson md 21204</b> |  |                             |  | 25a. DATE RECEIVED BY REGISTRAR <b>4 1984</b> SIGNATURE <b>Julia Davidson-Randall</b> |  |   |  |

11 FEB 1958

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 8 2

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Edna M. Burnett   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 30 84  |  |
| 3. SEX<br>Female  |  | 2b. HOUR<br>2:50   |  |
| 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 8 09  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |
| 8. CITY OR TOWN OF DEATH<br>Cockeysville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Broadmead        |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Balto.  |  |
| 13c. CITY OR TOWN<br>Cockeysville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>13801 York Road 21230  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Adolph Duge  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lucy Hankinson   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Unknown No   |  | 16b. SOCIAL SECURITY NO.<br>214-46-8963  |  |
| 17. INFORMANT ADDRESS<br>Elaine Davis - Same as #13e  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):<br>Vital Syndrome w/ dehydration   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. INJURY OCCURRED  |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (i) (the hospital) attended the deceased from 5/29/84 to 5/29/84 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body of the deceased.  |  |  |  |
| 22a. SIGNATURE<br>F. SANZARO  |  | 22b. DATE SIGNED<br>5/29/84  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>F. SANZARO   |  | 22d. ADDRESS<br>BROADMEAD  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>6-2-84  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Timonium, Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.   |  | 25. DATE REC'D. BY REGISTRAR<br>JUN 4 1984   |  |
| 25a. ADDRESS<br>1050 York Rd. Towson, Md. 21204   |  | 25b. REGISTRAR'S SIGNATURE<br>John Hankinson   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death certificate should be worked at once.



For Mr. [illegible] [illegible]

[illegible]

These items - same as [illegible]

11/11/11



1050 York St.  
 New York, N.Y. 10014  
 4-2-64  
 [illegible]  
 [illegible]  
 [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

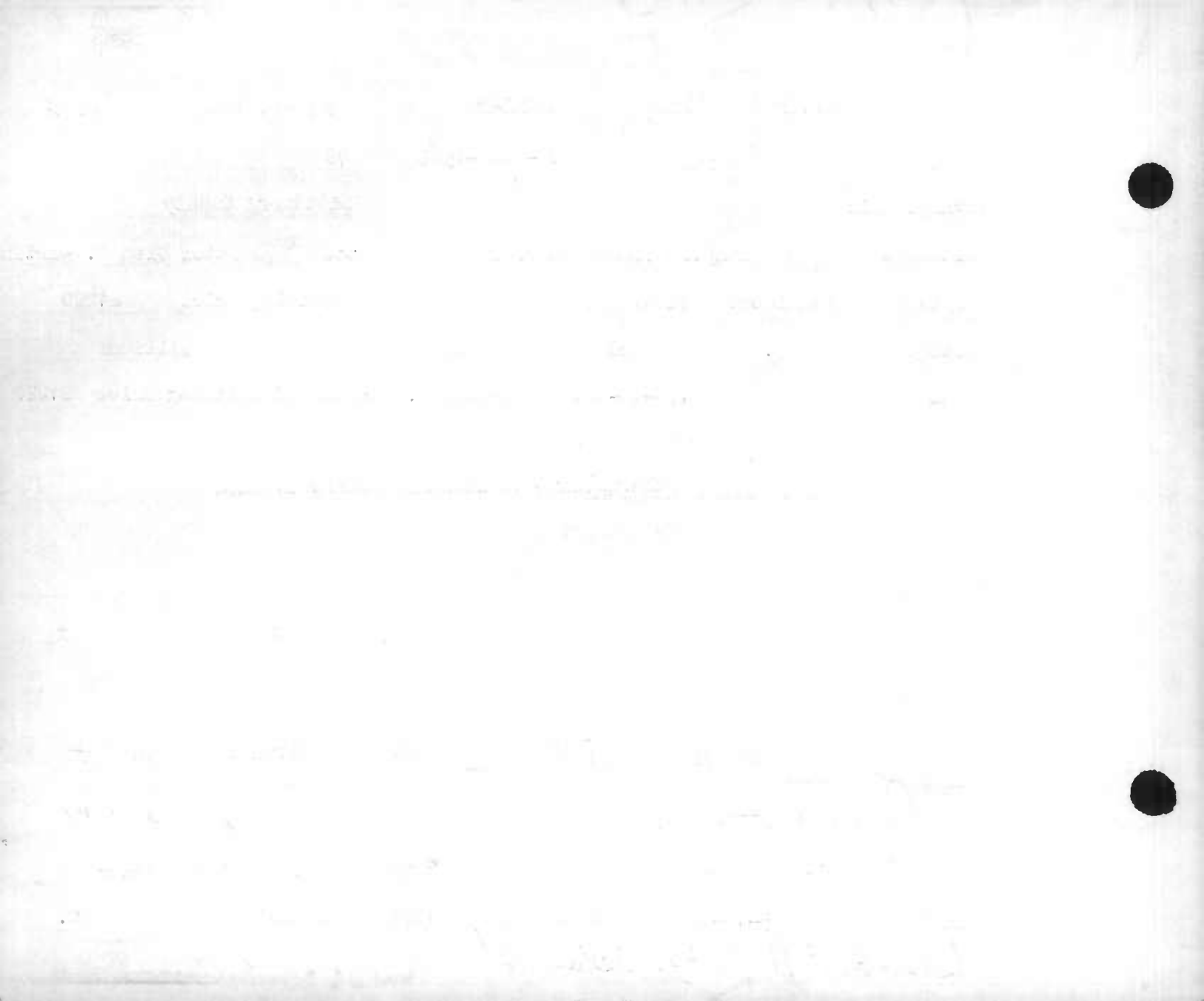
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |   |   |   |  |
|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |   | 2b. HOUR  |   |  |
| Walter Glenn BUSSARD   |  |  | May 16, 1984  |  |   | 4:38P M   |   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |   | 7. IF UNDER 1 YEAR  |   |  |
| Male   | White  | 2 - 16 - 1908  | 76 YRS.   |  |   | MONTHS DAYS HOURS MIN.  |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 9b. CITIZEN OF WHAT COUNTRY?   | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |   |   |   |  |
| Pennsylvania   | USA  |  | Baltimore County MD.  |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| Baltimore  | Franklin Square Hospital   |  | Stock Expediator  |  |   | Glen L. Martin  |   |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  |   | 13c. CITY OR TOWN   |   |  |
| Maryland   |  |  | Baltimore   |  |   | Baltimore   |   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   |  |
| George W. Bussard  |  |  | Ocy Williams  |  |   | no  |   |  |
| 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |   | ADDRESS   |   |  |
| 178-14-3810  |  |  | Arlene C. Bussard   |  |   | 22 Leftwing Drive 21220   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4140</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> |  |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |   |   |   |  |
|  |  | P.M. 19  |   |  |   |   |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |   |   |   |  |
| WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   | STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>82</u> , to <u>March 9</u> , 19 <u>84</u> , that (I/we) last saw the deceased alive on <u>May 16</u> , 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.  |  |  |   |  |   |   |   |  |
| 22b. SIGNATURE   |  |  |   |  |   | DEGREE  |   | 22c. DATE SIGNED                             |
| <u>Donald Richter MD</u>   |  |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 5-17-84                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |   | 22e. ADDRESS  |   |  |
| Donald Richter, MD.  |  |  |   |  |   | 9000 Franklin Square Drive 21237  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION   |   |  |
| Burial   |  | 5-19-84  |   | Mount Union Cemetery   |   | Bedford COUNTY Pa.  |   |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                   |
| NAME <u>Lashawn F H</u> ADDRESS <u>7407 Belair Rd</u>  |  |  |   |  |   | MAY 21 1984   |   | <u>Lashawn F H</u>                           |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |   |  |   |  |
|---|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MURRAY ANDERSON CAMPBELL</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-13-84</b>                  |   |  | 2b. HOUR<br><b>11:55pm</b>  |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 1, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.            |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                       |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Market Manager</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>                           |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Towson</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>12 Winthrop Court 21204</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Murray Campbell</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes Anderson</b>  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>705-09-0742</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Roberta J. Campbell Same</b>                    |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LEFT VENTRICULAR RUPTURE</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</b> |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/07</b> , 19 <b>84</b> , to <b>5/13</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert A. Palermo M.D.</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |   | 22c. DATE SIGNED<br><b>5/14/84</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT A. PALERMO, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>6701 NORTH CHARLES ST., BALTO., MD 21204</b>                |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>May 18, 1984</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bee Tree</b>                          |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkton, Balto., Co., Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>                            |   |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1864

1864

Paul W. Brown

1864

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 8 5

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET M. CANNON</b> |  |   | 2a. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>14</b> YEAR <b>1984</b> |   |  | 2b. HOUR<br><b>8<sup>10</sup> A.M.</b>  |  |
| 3. SEX<br><b>Female</b>                                       |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>June</b> DAY <b>27</b> YEAR <b>1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Saleslady Ret.</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                             |  |   |  |   |  |   |  |

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  | 13b. COUNTY<br><b>Baltimore</b>                |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>187 Bittings Avenue 21212</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Not Known</b> MIDDLE <b>Flaherty</b> LAST <b>Not Known</b>                                 |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bridget</b> MIDDLE <b>Not Known</b> LAST <b>Not Known</b> |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-24-4476</b> |  | 17. INFORMANT<br><b>Wyoming</b>  |  | ADDRESS<br><b>R.I. 02898</b>  |  | 17b. KIND OF BUSINESS OR INDUSTRY<br><b>Meadowbrook Rd.</b>        |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 DAYS</b> |  |
| 4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LEFT MIDDLE CEREBRAL ARTERY STROKE</b>  |  | <b>3 DAYS</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>          |  | <b>YEARS</b>   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-11</b> , 19 <b>84</b> , to <b>5-14</b> , 19 <b>84</b> , that (I) (over) lost saw the deceased alive on <b>5-13</b> , 19 <b>84</b> , and that in (my) (over) opinion death occurred on the date and hour and from the causes stated above, (I) (over) (did) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>John G. Lavin</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5-14-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN G. LAVIN</b>   |  |  |  | 22e. ADDRESS<br><b>6805 YORK RD ; BALT. MD 21212</b>                                 |  |  |  |

|  |  |                                 |  |  |  |   |  |
|--|--|---------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                   |  | 23b. DATE<br><b>May 17 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 18 1984</b> 25b. REGISTRAR'S SIGNATURE <b>G. Davidson-Randell</b> |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Continued

Salisbury County

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U.S.A.

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Salisbury, Md.

St. Joseph's Hospital

Township

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Continued

Salisbury County

St. Joseph's Hospital

Township

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Salisbury County

St. Joseph's Hospital

Township

Salisbury, Md. Salisbury, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 8 6

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |   |  |
|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PEARL E. CAREY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 17 84</b>                    |  |   | 2b. HOUR<br><b>4:05P M</b>  |  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 08 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD</b>  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FACTORY WORK</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mfg.</b>  |  |
| 13a. STATE<br><b>N.C.</b>  |  | 13b. COUNTY<br><b>Wilson</b>  | 13c. CITY OR TOWN<br><b>Wilson</b>                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br><b>211 RIDGE RD 27893</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIE T. DAVIS</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SALLY STRICKLAND</b> |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>unknown</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Ruth Swanson</b><br><b>5108 E. DURHAM RD</b><br><b>COLUMBIA, MD 21044</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis, bilateral</b><br><b>2396</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brain tumor</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/13</b> , 19 <b>84</b> , to <b>5/17</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/17</b> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Robert A. Palermo</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/18/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Palermo, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>6701 N. Charles St. Towson, MD 21204</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-21-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PEOPLES CHAPEL COM.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELM CITY WILSON N.C.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SLACK FUNERAL HOME</b>  |  | ADDRESS<br><b>Box 208</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 22 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

BP

999999



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 2 8 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                                     |   |   |   |  |  |
|--|--|---|--|---|-------------------------------------|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bertha Rose CARULLO                 |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 21, 1984                    |   |                                     | 2b. HOUR<br>3:36P M   |   |   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5/10/1906   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO., MD.                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  |   |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PRESSER |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>SHIRT MFR.                 |  |  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>ROSSVILLE      |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>5240 KING AVENUE 21237 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK                            |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY UNKNOWN          |   |                                     |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214.01.5555 |   | 17. INFORMANT<br>JOSEPHINE M. ROCHE |   | ADDRESS<br>50 ADMIRAL BOULEVARD<br>DUNDALK, MD. 21222   |   |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest, Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>May 19</u> , 19 <u>84</u> , to <u>May 21</u> , 19 <u>84</u> , that <u>we</u> last<br>saw the deceased alive on <u>May 21</u> , 19 <u>84</u> , and that in <u>our</u> opinion death occurred on the date and hour and from the causes stated<br>above. (We) (did) (not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Donald R. Richter MD</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><u>5-21-84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald R. Richter, MD  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |  |  |  |  |  |

|  |  |                        |  |  |  |  |  |
|--|--|------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                         |  | 23b. DATE<br>5/25/1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DUNDALK, BALTIMORE, MARYLAND |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 |  |                        |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rendall</u><br>MAY 23 1984 |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

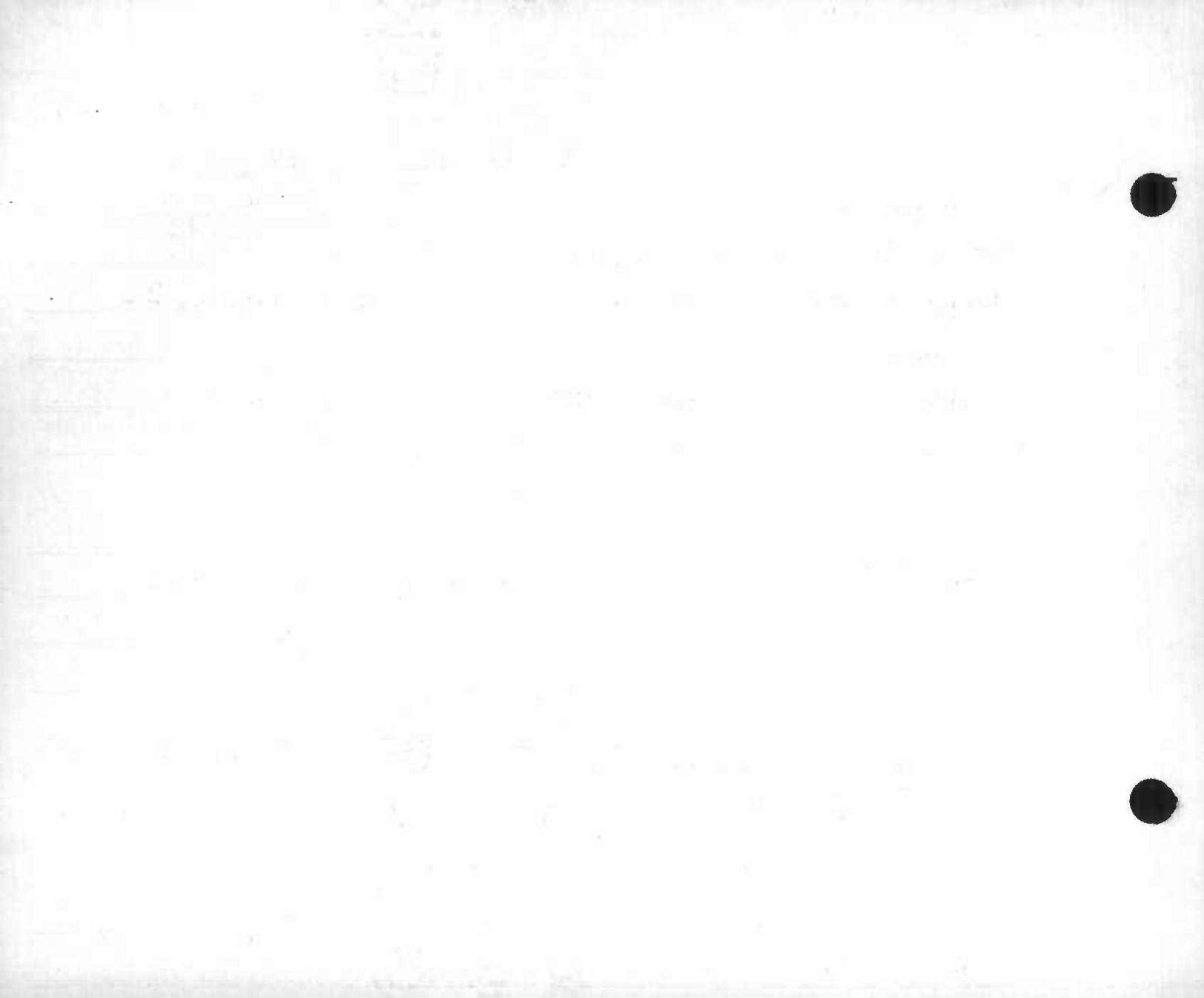
IMPORTANT: If item 21 is marked death item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   | REG. NO.  |  |                                   |   |                            |  |  |  |  |  |
|---|--|--|---|---|---|--|-----------------------------------|---|----------------------------|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR                              |  |                                   |   |                            |  |  |  |  |  |
| 1 DECEASED NAME FIRST MARY MIDDLE M. LAST CASEY   |  |  |   |   | 5/14/84 238 M   |  |                                   |   |                            |  |  |  |  |  |
| 3 SEX Female  |  | 4 RACE Can.  |   | 5 DATE OF BIRTH MONTH DAY YEAR  |   | 6 AGE (IN YEARS LAST BIRTHDAY)   |                                   | 7b. HOUR  |                            |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                                   | 10b. HOUR   |                            |  |  |  |  |  |
| Maryland  |  | U.S.   |   |   |   | Baltimore County   |                                   | MD.   |                            |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |                            |  |  |  |  |  |
| Catonsville   |  | Taves/Bland Bryant Nursing Center  |   |   | Housewife   |  | Home                              |   |                            |  |  |  |  |  |
| 13a. STATE  |  |  |   |   | 13b. COUNTY   |  | 13c. CITY OR TOWN                 |   | 13d. STREET ADDRESS        |  |  |  |  |  |
| Maryland  |  |  |   |   | Baltimore   |  | Essex                             |   | 10035 Marilyn Ave.         |  |  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  |   |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                     |  |                                   |   |                            |  |  |  |  |  |
| John Kopanski   |  |  |   |   | Anna Unkown   |  |                                   |   |                            |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |   |   | 16b. SOCIAL SECURITY NO                                       |  |                                   |   |                            | 17. INFORMANT ADDRESS                        |  |  |  |  |
| No  |  |  |   |   | 212-09-7451   |  |                                   |   |                            | Hospital Chart, Spring Grove Hosp.           |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) C.A. of the Larynx and 1619  |  |  |   |   |   |  |                                   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized metastases   |  |  |   |   |   |  |                                   |   |                            |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |   |   |  |                                   |   |                            |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes - Old CVA with Hemiplegia - ORS  |  |  |   |   |   |  |                                   |   |                            |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |   |                            |  |  |  |  |  |
|   |  |  | P.M. 19   |   |   |  |                                   |   |                            |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |   |                            |  |  |  |  |  |
|   |  |  |   |   |   |  |                                   |   |                            |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-31-1980 to 5-14-1984, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 5-14-1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. |  |  |   |   |   |  |                                   |   |                            |  |  |  |  |  |
| 22b. SIGNATURE  |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   |   | 22c. DATE SIGNED           |  |  |  |  |  |
| Cesar Valle Cervero M.D.  |  |  |   |   |   |  |                                   |   | 5-14-84                    |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   |   | 22e. ADDRESS   |                                   |   |                            |  |  |  |  |  |
| CESAR VALLE CERVERO   |  |  |   |   |   | Spring Grove Hospital Center   |                                   |   |                            |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY                            |  |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |                            |  |  |  |  |  |
| Burial  |  |  | 5-17-84   |   | Meadowridge Mem   |  |                                   | Elkridge Md.  |                            |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR  |                                   |   | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |
| MacNabb Funeral Home  |  |  |   |   |   | MAY 15 1984  |                                   |   | John Valle Cervero         |  |  |  |  |  |
| ADDRESS   |  |  |   |   |   |  |                                   |   |                            |  |  |  |  |  |
| Catonsville Md.   |  |  |   |   |   |  |                                   |   |                            |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elisabeth R. Cassutto</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 5, 1984</b> |   |  | 2b. HOUR<br>M<br><b>AM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 23, 1931</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>53</b>   |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.<br><b>00 00</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Netherlands</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockdale</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7222 Oak Haven Circle # 103</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher - Liberty High School</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Rockdale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7222 Oak Haven Circle #103 21207</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abraham Rodrigues</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leah Koopman</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>  |   | 17. INFORMANT<br><b>Baltimore, MD</b>   |  | ADDRESS<br><b>21207</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>MALIGNANT GLIOMA OF BRAIN</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 HR</b><br><b>6 MOS</b>  |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2435 W. Belvedere Baltimore MD 21215</b>  |  |  |  |  |  |
| 22a. I certify that (I) (if is hospital) attended the deceased from <b>JAN 19 84</b> to <b>MAY 5 19 84</b> , that (I) (we) lost <b>APRIL 5 1984</b> above, (I) (we) did (did not) view the body after death.  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Howard Weiss MD</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>5-5-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Howard Weiss</b>  |  |   |   | 22e. ADDRESS<br><b>2435 W. Belvedere Baltimore MD 21215</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/8/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>W. Friendship Howard Maryland</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>MAJ 7 1984</b>  |  |  |  |
| 26. ADDRESS<br><b>8728 Liberty Rd. Randallstown, MD 21133</b>   |  |   |   |   |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE E CATHORNE</b>   |  |  |  |
| 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR   |  | 3. SEX<br>Male   |  | 4. RACE<br>Black   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| 6 MONTH 10 DAY 16 YRS  |  | 67 YRS   |  | MD   |  | USA  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CO. GENERAL HOSPITAL          |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>MD   |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>4507 Dunland Road 21229  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Amenius Henderson  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Mable Cothorn  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-05-7519  |  | 17. INFORMANT<br>Shirley A. Cathorne 32 Pendragon Court  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) <u>Cancer of colon with metastasis of liver with ascites</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-27-</u> 19 <u>84</u> to <u>5-12-</u> 19 <u>84</u> , that (I) (we) lost <u>saw the deceased alive on 5-12-84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Soonchal Hong</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>5-12-84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SOONCHAL HONG</u>  |  |  |  | 22e. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>5/17/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills, Md.  |  |
| 24. FUNERAL DIRECTOR<br>Wm C March F/H Inc. 1101 E North Avenue  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1984   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>J. Davidson-Randall</u>   |  |  |  |  |  |  |  |

1511

(A)

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*[Faint, mostly illegible handwritten text and markings across the page, possibly including dates and names.]*

100%

| FOR<br>1- STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LILLIAN J. CEDRONE   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 10 '84   |  |   |  | 2b. HOUR<br>1:40A  |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 14 '25   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES ST. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>103 Tenbury Road 21093                             |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Butler   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie Naomi Tarrell  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213-20-2176   |  | 17. INFORMANT<br>ADDRESS<br>Henry M. Cedrone same as 13 e   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RUPTURED AORTIC ANEURYSM<br>4415<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>5/10/84   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>RUPTURED AORTIC ANEURYSM  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10 1984 to 5/10 1984, that (I) (we) last saw the deceased alive on 5/10 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Edward P. Grace M.D.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>5/10/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD P. GRACE, M.D.  |  |   |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES STREET 21204   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5-12-1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium Maryland                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.  |  |   |  | ADDRESS<br>1050 York Road Towson, Maryland  |  |   |  | 25a. DATE REG'D. BY REGISTRAR<br>MAY 11 1984   |  |  |  |



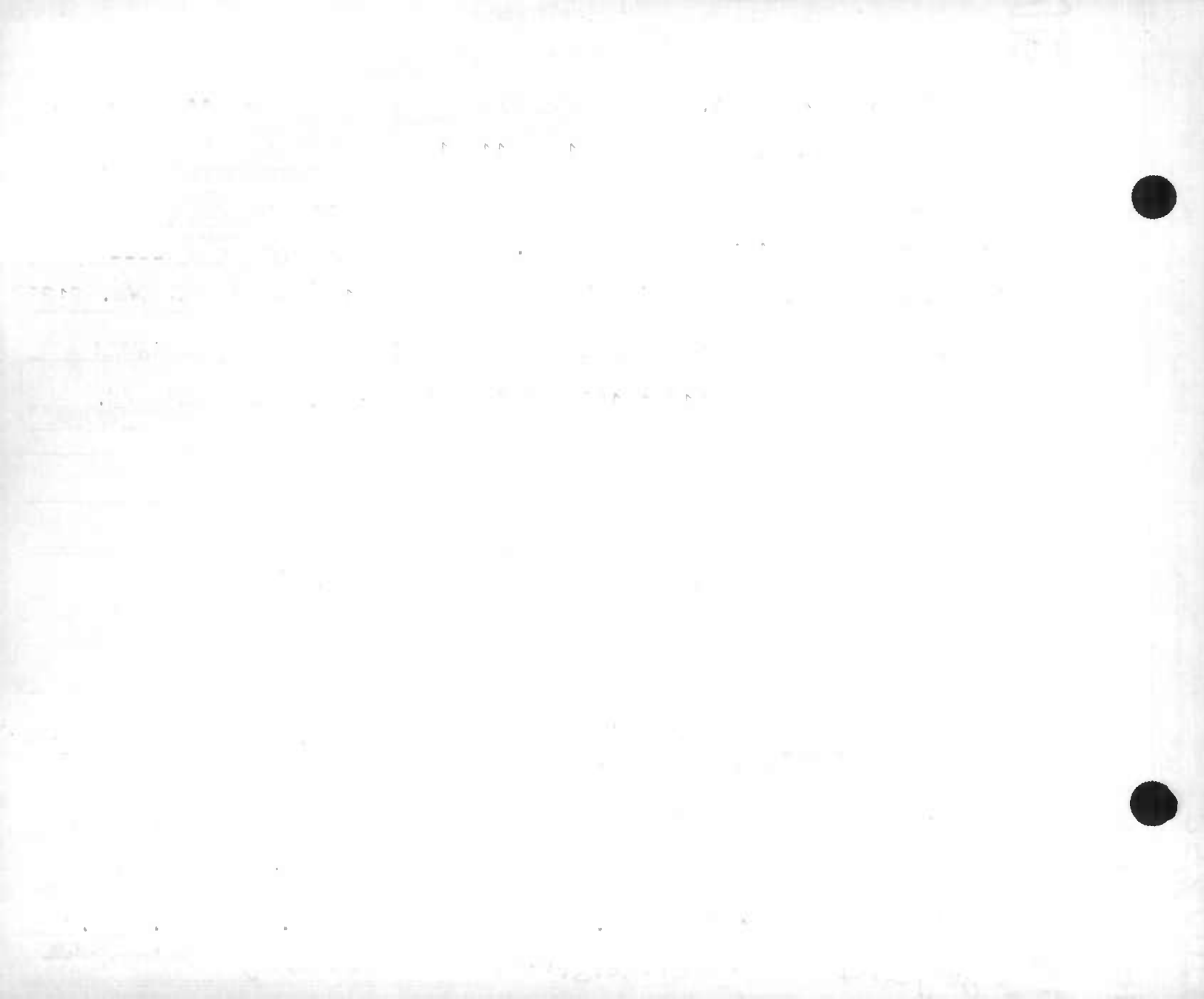
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE (MARY) A. CHERIGO</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>05</b> DAY <b>11</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>2:10 A M</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>11</b> YEAR <b>19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSEDALE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8104 WOODHAVEN AVE.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>   |  |   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>ROSEDALE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>JOSEPH</b> MIDDLE <b>KOWALEWSKI</b> LAST <b>JOSEPHINE</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>JOSEPHINE</b> MIDDLE <b>SCHRADER</b> LAST <b>SCHRADER</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213013123</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>PAT MARKLEY 8006 NEIGHBORS AVE.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Sarcoma</b><br><b>1719</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes</b>  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>6-78</b> to <b>5-11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5-9</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Marie C. Kowalewski</b>   |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5-11-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.C. KOWALEWSKI</b>  |  |   |  | 22e. ADDRESS<br><b>8604 HARFORD RD 21234</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/14/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>[Signature]</b> ADDRESS <b>1211 Chesapeake Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |   |
|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Tong Pae Cho</b>  |  |  | 2a. DATE OF DEATH <b>May 23, 1984</b>                            |   | 2b. HOUR <b>M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Yellow</b>   | 5. DATE OF BIRTH<br><b>June 9 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Korea</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Korea</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>947 Bayner Rd.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Essex 21221</b>                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213 62 9939</b>   |  | 17. INFORMANT<br><b>Young Che Chong</b> ADDRESS <b>Same</b>                                     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic colon carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5/23</b> , 19 <b>84</b> , to <b>5/23</b> , 19 <b>84</b> , that (2) (we) lost<br>saw the deceased alive <b>5/23</b> , 19 <b>84</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><b>S. Miller MD</b>  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/24/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MILNER</b>   |  | 22e. ADDRESS<br><b>5400 Old Court Rd (21137)</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>5/26/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                  |   |
| 23d. LOCATION<br><b>Baltimore Co., Md.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1984</b>  |  |   |   |
| 23f. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  | 23g. REGISTRAR'S NAME<br><b>John Davidson</b>  |  |   |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUBIN REUBEN CHOMET</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 29 '84</b>                 |   |  | 2b. HOUR<br><b>10:02 PM</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APR. 13, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE WHICH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTRICIAN</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>IGNATZ CHOMET</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA SITZ</b>  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>091-07-0278</b>  |  | 17. INFORMANT<br><b>MRS. ANN CHOMET APT. A</b><br><b>2809 DAMASCUS CT. BALTO., MD 21209</b> |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>400</b><br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>MYOCARDIAL INFARCTION</b> |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
|   |  |  |  |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>NEPHRECTOMY (LEFT)</b>   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/28</b> , 19 <b>84</b> , to <b>5/29</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>T. HERCING</b>   |  |  |  |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>5/29/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T. HERCING</b>  |  |  |  |   | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE<br><b>MAY 31, 1984</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEM. PARK</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN BALTO. MD</b> |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 6 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swinson-Rodgers</b>                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or initialed, it shows any injury, or other traumatic event, the medical examiner should be notified at once.

WILLIAMSON COUNTY

WILLIAMSON COUNTY

WILLIAMSON COUNTY

WILLIAMSON COUNTY

WILLIAMSON COUNTY

WILLIAMSON COUNTY

WILLIAMSON COUNTY

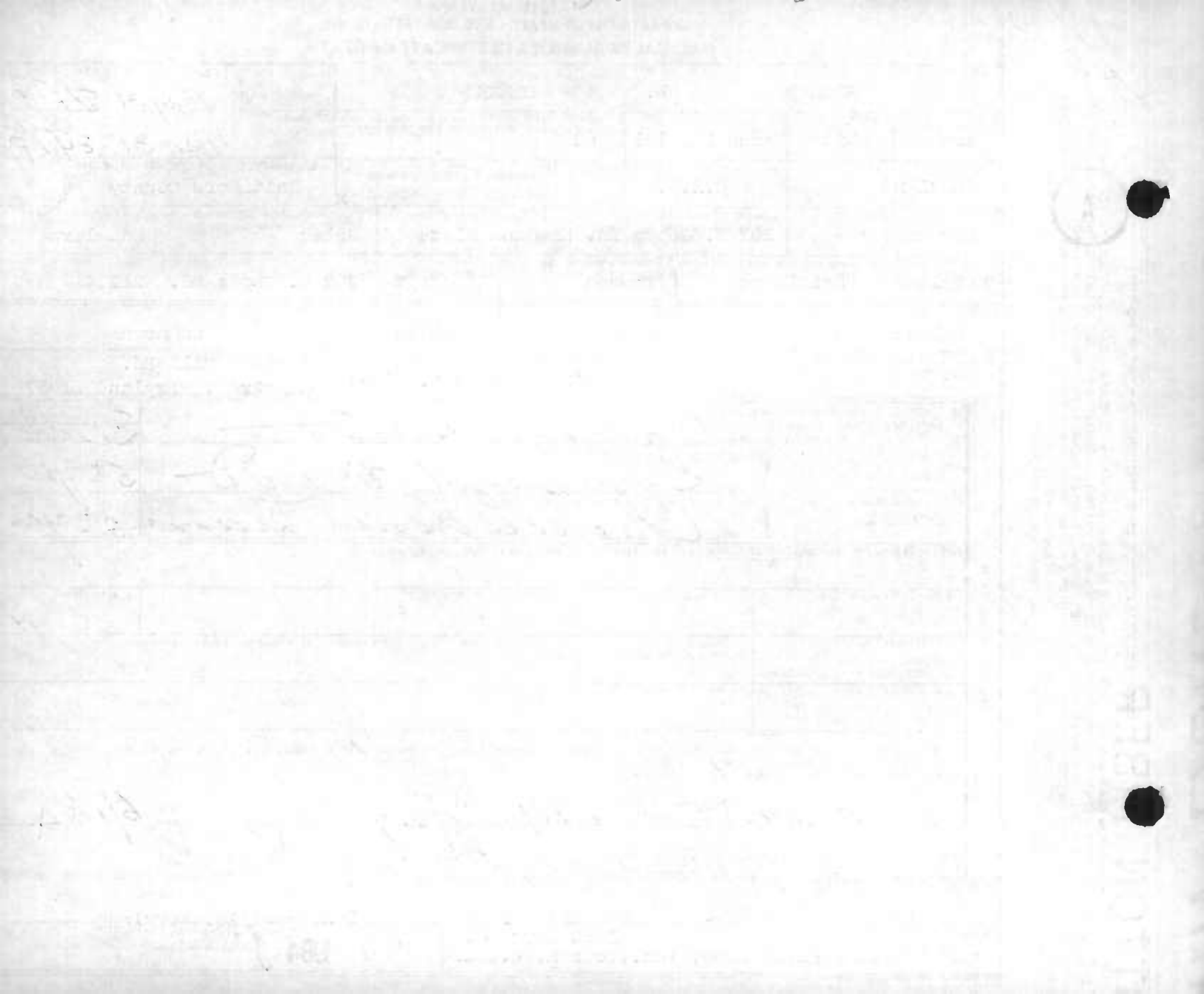
WILLIAMSON COUNTY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |  |  | REG. NO.   |  |
|--|--|-------------------------|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ESTHER L. CLARK</b>   |  |                         |  |   |  | 2a. DATE KNOWN<br>DEATH ESTIMATED <b>May 31 1984</b> |  | 2b. HOUR<br><b>7P</b>  |  | 2c. MONTH<br><b>May</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 18, 1916</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>68</b>      |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b>   |  | 7c. DATE<br>PRONOUNCED<br>DEAD <b>May 31 1984</b>  |  |
| 8. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |                         |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>302 E. Joppa Rd. Hampton Plaza</b> |  |  |  | 14. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Sales</b>  |  | 15. KIND OF BUSINESS<br>OR INDUSTRY<br><b>Hutzlers</b>   |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>Maryland</b>   |  |                         |  | 16b. CITY OR TOWN<br><b>Baltimore</b>   |  |  |  | 16c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 16d. STREET ADDRESS<br><b>302 E. Joppa Rd. 21204</b>   |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Adams</b>  |  |                         |  | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther unknown</b>  |  |  |  | 19. INFORMANT<br>ADDRESS<br><b>11 Windy Hill Rd.<br/>Glen Arm, Maryland 21057</b>  |  |  |  |
| 20a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                         |  | 20b. SOCIAL SECURITY NO.<br><b>213-30-9261</b>  |  |  |  | 20c. DATE OF DEATH<br><b>May 31 1984</b>   |  |  |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Generalized Asystole</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Renal Disease</b>                                       |  |                         |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>5± yrs</b><br><b>2± yrs</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                         |  |   |  |  |  |  |  |  |  |
| 22a. DATE OF OPERATION   |  |                         |  | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 22c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 23a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 23b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 24a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 24b. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |  |  | 24c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 25a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Charles F. O'Donoghue</b>  |  |                         |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |  |  | DATE SIGNED <b>6/1/84</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>CHARLES F. O'DONOGHUE</b>  |  |                         |  | ADDRESS<br><b>2501 York Rd.</b>   |  |  |  |  |  |  |  |
| 26a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |                         |  | 26b. DATE<br><b>6-5-84</b>  |  |  |  | 26c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  |  |  |
| 26d. LOCATION<br>CITY OR TOWN<br><b>Cockeysville, Maryland</b>   |  |                         |  | 26e. COUNTY<br><b>Harford</b>   |  |  |  | 26f. STATE<br><b>Md.</b>   |  |  |  |
| 27. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  |                         |  | ADDRESS<br><b>1050 York Rd.<br/>Towson, Md. 21204</b>   |  |  |  | 28. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1984</b>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |   |  |  |
|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>First: <u>Elise</u> Middle: <u>B.</u> Last: <u>Clawson</u>  |  |  | 2a. DATE OF DEATH<br>MONTH: <u>05</u> DAY: <u>30</u> YEAR: <u>84</u> |  | 2b. HOUR<br><u>10<sup>40</sup></u> P.M. |  |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>White</u>  |  | 5. DATE OF BIRTH<br>MONTH: <u>12</u> DAY: <u>01</u> YEAR: <u>93</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>90</u> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Cuba</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Balt. County</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Stella Maris</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Homemaker</u>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><u>md</u>  |  | 13b. COUNTY<br><u>Balto</u>  |  | 13c. CITY OR TOWN<br><u>Baldwin</u>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>First: <u>Angelo</u> Middle: <u>BARRERIO</u> Last: <u>Adala</u>   |  | 15. MOTHER'S MAIDEN NAME<br>First: <u>Adala</u> Middle: <u>BRUNGT</u> Last: <u>BRUNGT</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><u>312-01-6068-06</u>  |  |
| 17. INFORMANT<br><u>Edith C. McNabb</u>  |  | ADDRESS<br><u>same</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><u>4292</u> IMMEDIATE CAUSE (a) <u>ASCVD Arteriosclerotic Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><u>5/24/84</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Right inguinal hernia repair</u>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>84</u> , to <u>5/30</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>5/30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>KR Faulkner MD</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   | 22c. DATE SIGNED<br><u>5/30/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Kendall Faulkner</u>   |  | 22e. ADDRESS<br><u>Stella Maris</u>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |   | 23b. DATE<br><u>6/7/84</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Jolancy Valley Manor Gds</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Cockeysville Balto Md</u>   |  | 24. NAME OF DECEASED DIRECTOR<br><u>M. F. Hall-Wiedefeld Hono</u>  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 5 1984</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  | 25c. ADDRESS<br><u>6500 York Rd</u>  |  | 25d. DATE<br><u>JUN 5 1984</u>   |   |  |  |

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TO : DIRECTOR, FBI (100-388610)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report body.]



100-388610-100000  
FBI  
NEW YORK  
JUN 10 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>AGNES V. CLAYPOOLE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 21, 1984</b>                                      |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 1, 1908</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Timonium</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>62 Oakway Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Timonium</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>62 Oakway Rd. 21093</b>                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel P. Donnelly</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Downs</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-05-7254</b>  |   | 17. INFORMANT ADDRESS<br><b>Frank J. Claypoole - Same as #13e</b>              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><b>1890</b> IMMEDIATE CAUSE (a) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Carcinomatosis</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF <b>Transitional cell CA, left kidney</b><br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 10</b> , 19 <b>74</b> , to <b>May 21</b> , 19 <b>84</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>May 21</b> , 19 <b>84</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |   |  |  |
| 27b. SIGNATURE<br><i>Donald O. Wood</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 27c. DATE SIGNED<br><b>5/22/84</b>   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald O. Wood, M.D.</b>  |  | 27e. ADDRESS<br><b>2 Greenmeadow Drive Timonium, Md.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>5-24-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium, Baltimore, Maryland</b>              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Handall</i>                                     |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 1 2 2 9 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Evelyn M Collins  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-10-84                                |  | 2b. HOUR<br>10:25am  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 5, 1921  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Joseph Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   |   | 13b. CITY OR TOWN<br>Baltimore  | 13c. CITY OR TOWN<br>21204   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward E. Cross   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Mae Davis               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>219-05-5977   |   | 17. INFORMANT<br>ADDRESS<br>21204<br>Norman H. Collins, Jr. 1631 Cottage Lane        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>days<br>days  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-7</u> , 19 <u>84</u> , to <u>5-10</u> , 19 <u>84</u> . that (I) (we) lost<br>saw the deceased alive on <u>5-10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Maurice B. Furlong</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>5-10/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Maurice B. Furlong, M.D.   |   | 22e. ADDRESS<br>7620 York Road Towson Md 21204  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment  |   | 23b. DATE<br>May 14, '84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson  |   |   | 25. DATE RECEIVED BY REGISTRAR<br>MAY 11 1984                                 |  |  |
| ADDRESS<br>8521 Loch Raven Blvd.  |   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



#5 FilmG582 6/12/84 kam  
 FOR  
 1- STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |                           |  |
|--|--|---|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY W. COVERT</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 31, 1984</b> |  | 2b. HOUR<br><b>6:10</b> M |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8, 1901</b>                            |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                                    |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FREDERICK VILLA NURSING CENTER</b>          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                  |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ADT PROTECTION</b> |  |                           |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>HOWARD</b>  |  | 13c. CITY OR TOWN<br><b>SYKESVILLE</b>   |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES WILLIAM COVERT</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA MAE FOLK</b>  |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-2962</b>  |  | 17. INFORMANT ADDRESS<br><b>ROSALIE COVERT - Same as Sec. 13</b>                     |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Terminal Stage of CA of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>Months</b> |  |   |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/29/84</b> to <b>5/31/84</b> , that (I) (we) last saw the deceased alive on <b>5/29/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |                           |  |
| 22b. SIGNATURE<br><b>Dr. Adnan M. Sonmez</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/31/84</b>   |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Adnan M. Sonmez</b>  |  | 22e. ADDRESS<br><b>500 N. Rolling Rd. Catonsville, MD. 21228</b>  |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-4-1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                    |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>  |  |  |                           |  |
| 23f. REGISTRAR'S SIGNATURE<br><b>Leroy M. &amp; Russell C. Witzke</b>  |  |   |  |  |                           |  |
| 23g. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>1630 Edmondson Ave., Catonsville, MD. 21228</b>  |  |   |  |  |                           |  |

MEDICAL CERTIFICATION

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BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |                                      |  |   |  |  |
|--|--|--|--|---|--------------------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Howard Charles Cox, Sr.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 21 1984</b>                |   |                                      | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 4 1910</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                    |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County Md.</b>                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Balto. Med. Ctr.</b> |  |   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Continental Can Co.</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Timonium</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas E. Cox</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa Hufnagel</b> |   |                                      | 13e. STREET ADDRESS / ZIP CODE<br><b>86 E. Padonia Rd., 21093</b>                    |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-5823</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret M. Cox, 86 E. Padonia Rd., 21093</b>  |                                      |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Autochthonous Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>year</b> |  |  |  |   |                                      |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>no</b>  |  |  |  |   |                                      |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  |   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>  |                                      |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/21</b> , 19 <b>84</b> , to <b>5/21</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                                      |  |   |  |  |
| 22b. SIGNATURE<br><b>Thomas N. Ferciot</b>   |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      |  |   | 22c. DATE SIGNED<br><b>5/24/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas N. Ferciot, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>1818 Pot Springs Rd., 21093</b>  |                                      |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/24/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium Balto. Md.</b>             |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>J. E. Lowell Lemmon, 10 W. Padonia Rd.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1984</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                           |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Nov 23 1903

Received of the  
County of  
the sum of  
Twenty Dollars  
for  
the year 1903

Witness my hand and seal  
this 23rd day of November 1903

Attest:  
County Clerk  
Nov 23 1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a copy of the report will be furnished to you.

## MEDICAL CERTIFICATION

| EDWINA L. CRAMER  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWINA L Cramer</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>12</b> YEAR <b>84</b>   |  |  |  | 2b. HOUR<br><b>10:45</b> AM  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>                |  | 5. DATE OF BIRTH<br>MONTH <b>07</b> DAY <b>05</b> YEAR <b>18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                    |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                |  | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD. |  |  |  |   |  |
| 13. CITY OR TOWN OF DEATH<br><b>ROSEDALE</b>  |  |  |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2002 LONGVIEW CT.</b>                                |  |  |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BINDER</b> |  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>ROSEDALE</b>  |  |  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 18. STREET ADDRESS<br><b>2002 LONGVIEW CT. 21237</b>                             |  |   |  |
| 19. FATHER'S NAME<br>FIRST <b>HERBERT</b> MIDDLE <b>W.</b> LAST <b>HARVEY</b>   |  |  |  | 20. MOTHER'S MAIDEN NAME<br>FIRST <b>SARA</b> MIDDLE <b>MARGARET</b> LAST <b>KIRK</b>  |  |  |  | 21. ADDRESS<br><b>2002 LONGVIEW CT.</b>  |  |   |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  | 23. SOCIAL SECURITY NO.<br><b>218225661</b>  |  |  |  | 24. INFORMANT<br><b>CAROL PFEFFER 2002 LONGVIEW CT.</b>                          |  |   |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Vocal cord paralysis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic breast cancer in lymphatic system</b><br>1749 |  |  |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |  |  |  |  |  |  |  |  |   |  |
| 26. DATE OF OPERATION   |  |  |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |  |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 33. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 36. I certify that (I) (this hospital) attended the deceased from <b>8-1-83</b> to <b>5-12-84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5-12-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (not) view the body after death.          |  |  |  |  |  |  |  |  |  |   |  |
| 37. SIGNATURE<br><b>K. S. NAIR</b>  |  |  |  | 38. DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 39. DATE SIGNED<br><b>5-12-84</b>  |  |   |  |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. S. NAIR</b>   |  |  |  | 41. ADDRESS<br><b>5010 York Road<br/>BALTIMORE, MD 21212</b>   |  |  |  |  |  |   |  |
| 42. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>CREMATION</b>  |  |  |  | 43. DATE<br><b>5/15/84</b>   |  | 44. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW CREMATORY</b>       |  | 45. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD.</b>            |  |   |  |
| 46. FUNERAL DIRECTOR<br><b>1211 Chesapeake</b>  |  |  |  | 47. ADDRESS<br><b>1211 Chesapeake</b>  |  |  |  | 48. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1984</b>                               |  |   |  |
| 49. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>  |  |  |  |  |  |  |  |  |  |   |  |

BP

REWARD



|    |    |    |    |    |    |    |    |    |     |
|----|----|----|----|----|----|----|----|----|-----|
| 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10  |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20  |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30  |
| 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40  |
| 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50  |
| 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60  |
| 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70  |
| 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80  |
| 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90  |
| 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |



100% COTTON

MADE IN THE U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |   |
|--|--|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elsie M. Crudden   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 26, 84 |   |  | 2b. HOUR<br>10:00 PM  |   |
| 3 SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 20, 1891  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE Co. MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>INGLENOK NURSING CENTER |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Eng. Electronic  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE CITY<br>MARYLAND City   |  |  |   | 13b. CITY OR TOWN<br>BALTIMORE  |  | 13c. STREET ADDRESS / ZIP CODE<br>2012 Wittier Ave. 21217   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Wilson Crudden  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosa Lee Eno   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-10-3832  |   | 17. INFORMANT<br>Rev. Robert Read-Edmondson at W/nans   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u><br>4370<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis Cardio Vasc. Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>yes</u>  |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>   |  |  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-22-</u> 19 <u>65</u> to <u>5-26-</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5-25-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) (did not) view the body after death. |  |  |   |   |  |   |   |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>6/28/84</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HARRY L. KNIPP, MD.   |  | 22e. ADDRESS<br>5411 Old Frederick Rd. 21229   |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>Cremation   |  | 23b. DATE<br>May 28, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory Westview Balto. MD.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |
| 24. FUNERAL DIRECTOR<br>Leroy M. Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Ave., Catonsville, MD. 21228   |  |  |   | 25. DATE RECD. BY REGISTRAR<br>MAY 29 1984  |  |   |   |
| 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |   |   |  |   |   |

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*[Faint, illegible handwriting and text throughout the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph J. Cushman  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 18 84 |   |  | 2b. HOUR<br>8:40 AM   |  |   |  |  |  |
| 1. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 30 20   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7b. IF UNDER 24 HRS.<br>HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>BETH. ST. 21234 |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Md. |  |  |  |   |  | 13c. CITY OR TOWN<br>Baltimore Parkville                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13. STREET ADDRESS / ZIP CODE<br>8708 Stockwell Rd |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Cushman  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha Winkler               |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>W.W.I. 23 16 6037  |  | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS  |  |   |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

5750  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF  
(b) Acute Cholecystitis  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Autoimmune Hemolysis - Thrombocytopenia - Hyponatremia

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If not, (did) (did not) see the body after death.) |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br>5/18/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS<br>ST. JOSEPH HOSPITAL  |  |  |  |

|  |  |                          |  |   |  |  |  |
|--|--|--------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial               |  | 23b. DATE<br>May 21 1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Evans Chapel of Memories Harford Rd. |  |                          |  | 25a. DATE REC'D. BY REGISTRAR<br>8800<br>MAY 23 1984    |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Rendall                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

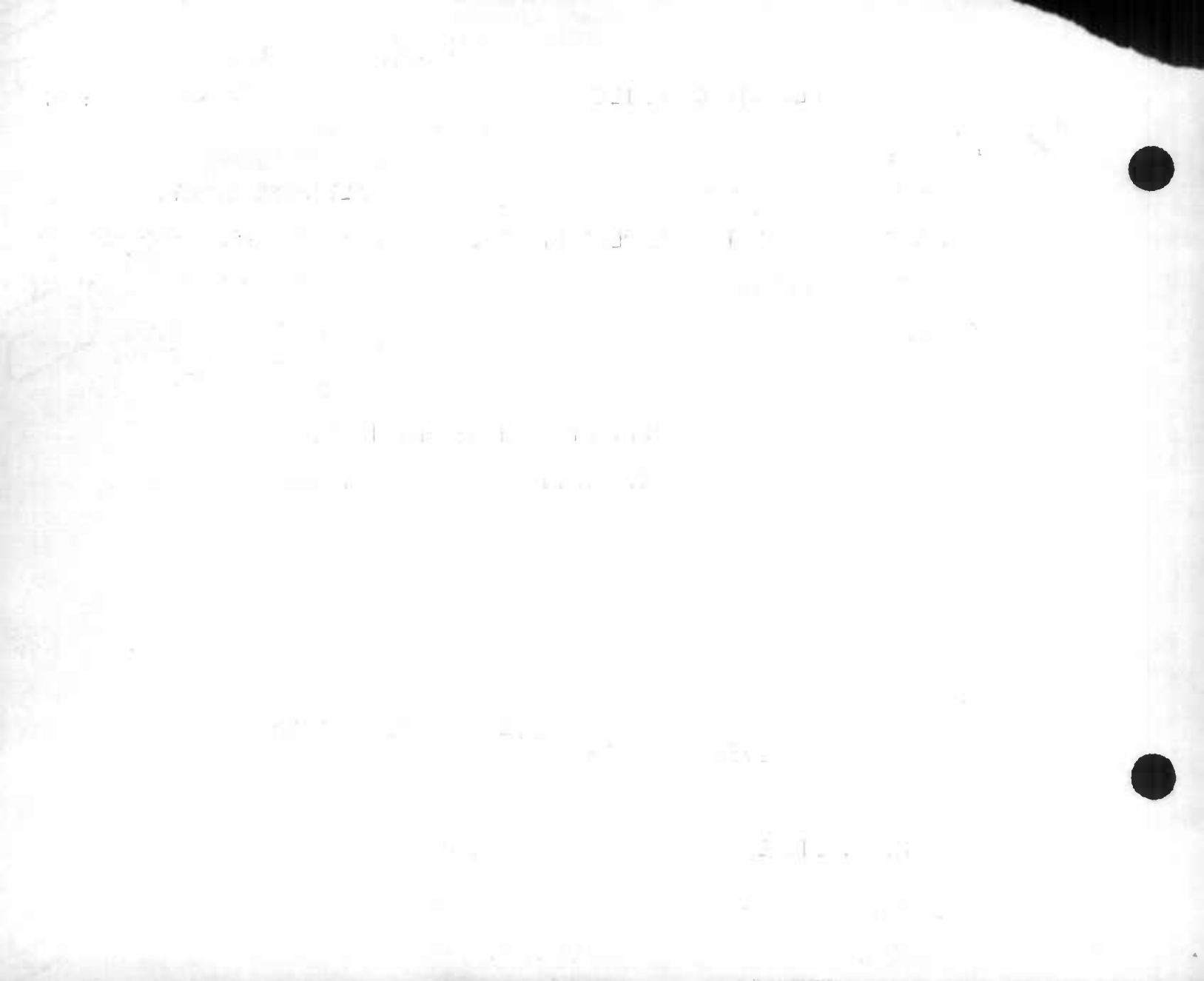
|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLAUDIA C DAILEY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/30/84</b>   |   | 2b. HOUR<br><b>4:40 PM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 26 35</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b>                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.               |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>EXECUTIVE SEC.</b>       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MACHINERY CO.</b>  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>WHITE MARSH</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>11540 Philadelphia Rd. Lot 14 21162</b>      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES FREDERICK DAILEY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE CECELIA DONAHUE</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-7104</b>  |   | 17. INFORMANT (ADDRESS)<br><b>CATHERINE MITCHELL ESSEX, MD. 21221</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749 IMMEDIATE CAUSE (a) RESPIRATORY INSSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>METASTATIC BREAST CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> , 19 <b>84</b> , to <b>5/30</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |   |   |  |
| 22b. SIGNATURE<br><b>P. Siemer MD</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. P. SIEMER</b>   |  | 22e. ADDRESS<br><b>GBMC</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>REMOVAL</b>  |  | 23b. DATE<br><b>5/30/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ANATOMY BOARD</b>  |  | ADDRESS<br><b>BALTO., MD.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1984</b>                                |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |        |  |                   |   |       |  |           |  |  |
|---|--|--|--------|--|-------------------|---|-------|--|-----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  | MIDDLE | LAST   | 2a. DATE OF DEATH |   | MONTH | YEAR   | 2b. HOUR  |  |  |
| Florence  |  | M.   |        | Dance  | 5 20 84           |   |       |  | 1:15 P.M. |  |  |
| 3. SEX  |  | 4. RACE  |        | 5. DATE OF BIRTH   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |       | IF UNDER 1 YEAR  |           | IF UNDER 24 HRS                              |  |
| Female  |  | white  |        | 3 27 1891  |                   | 93 YRS.   |       | MONTHS DAYS  |           | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |       |  |           |  |  |
| Baltimore   |  | USA  |        |  |                   | Baltimore Co. MD.   |       |  |           |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |       | 12b. KIND OF BUSINESS OR INDUSTRY                              |           |  |  |
| Dundalk   |  | MERIDIAN → HERITAGE  |        |  |                   | Bookkeeper  |       | -  |           |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |        |  |                   |   |       |  |           |  |  |
| 13a. STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?  |       | 13e. STREET ADDRESS  |           |  |  |
| MD.   |  | BALTO  |        | Parkville  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 1523 ORLANDO RD. 31234   |           |  |  |
| 14. FATHER'S NAME   |  |  |        | 15. MOTHER'S MAIDEN NAME   |                   |   |       |  |           |  |  |
| CHARLES   |  |  |        | PENN   |                   |   |       | MARY   |           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |        | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT   |       | ADDRESS  |           |  |  |
| No  |  |  |        | 218-03-2613  |                   | Mr. Frederick R. Emmel  |       | Same as # 13e  |           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |        |  |                   |   |       |  |           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |        |  |                   |   |       |  |           |  |  |
| IMMEDIATE CAUSE (a) Acute Respiratory Arrest  |  |  |        |  |                   |   |       |  |           |  |  |
| 4029  |  |  |        |  |                   |   |       |  |           |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |        |  |                   |   |       |  |           |  |  |
| (b) H.C.V.D.  |  |  |        |  |                   |   |       |  |           |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |        |  |                   |   |       |  |           |  |  |
| (c)   |  |  |        |  |                   |   |       |  |           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |        |  |                   |   |       |  |           |  |  |
| NONE  |  |  |        |  |                   |   |       |  |           |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |  |                   | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |           |  |  |
| N/A   |  | N/A  |        |  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |           |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                   |   |       |  |           |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |        | N/A  |                   |   |       |  |           |  |  |
|   |  | P.M. 19  |        |  |                   |   |       |  |           |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION  |                   | CITY OR TOWN  |       | COUNTY   |           | STATE  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | N/A  |        | N/A  |                   |   |       |  |           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-27, 1982, to 5-20, 1984, that (I) (we) lost the deceased alive on 5-20, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |        |  |                   |   |       |  |           |  |  |
| 22b. SIGNATURE  |  |  |        |  |                   | DEGREE  |       | 22c. DATE SIGNED   |           |  |  |
| Theo. C. Patterson  |  |  |        |  |                   |   |       | 5-20-84  |           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |        |  |                   | 22e. ADDRESS  |       |  |           |  |  |
| THEO. C. PATTERSON  |  |  |        |  |                   |   |       |  |           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION   |       | CITY OR TOWN   |           | COUNTY STATE                                 |  |
| Burial  |  | 5-23-84  |        | Parkwood   |                   | Baltimore, Maryland   |       |  |           |  |  |
| 24. FUNERAL DIRECTOR  |  |  |        |  |                   | 25a. DATE REC'D. BY REGISTRAR                                       |       | 25b. REGISTRAR'S SIGNATURE                                     |           |  |  |
| NAME  |  |  |        |  |                   | MAY 22 1984   |       | John Davidson-Randall  |           |  |  |
| Leonard J. Ruck, Inc.   |  |  |        |  |                   | Baltimore, Md.  |       |  |           |  |  |

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4-2-20

to: Mr. J. H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 12306  |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <del>DEAN DANER</del> Edna M. DANEKER  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 5/18/84  |  |
| 3. SEX FEMALE  |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR May 26, 1914                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.   |  |
| 10. CITY OR TOWN OF DEATH Towson, Md   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.                         |  |
| 13a. STATE Maryland  |  | 13b. COUNTY -  |  | 13c. CITY OR TOWN Baltimore   |  |
| 13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE 1357 Weldon Avenue 21211  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wrapper             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store  |  | 14. FATHER'S NAME FIRST MIDDLE LAST Leonard E. Sentz   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence I. Switzer                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO. 220 14 2760A  |  | 17. INFORMANT ADDRESS Ray L. Daneker same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1991 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic adenocarcinoma with</u> 2 years<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>primary tumor in pelvis</u> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE <u>Indie Monte, MD</u>  |  | DEGREE   |  | 22c. DATE SIGNED 5/18/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. M. de la Monte</u>   |  | 22e. ADDRESS <u>St. Joseph Hospital</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 5/21/84  |  | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery                              |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Co. Maryland   |  | 24. FUNERAL DIRECTOR NAME Burgee Funeral Home 3631 Falls Road 21211  |  | 25a. DATE REC'D. BY REGISTRAR MAY 21 1984   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Jessie Davidson-Randall</u>                         |  |

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Item 13a, 24  
ITEM#1 8/29/89  
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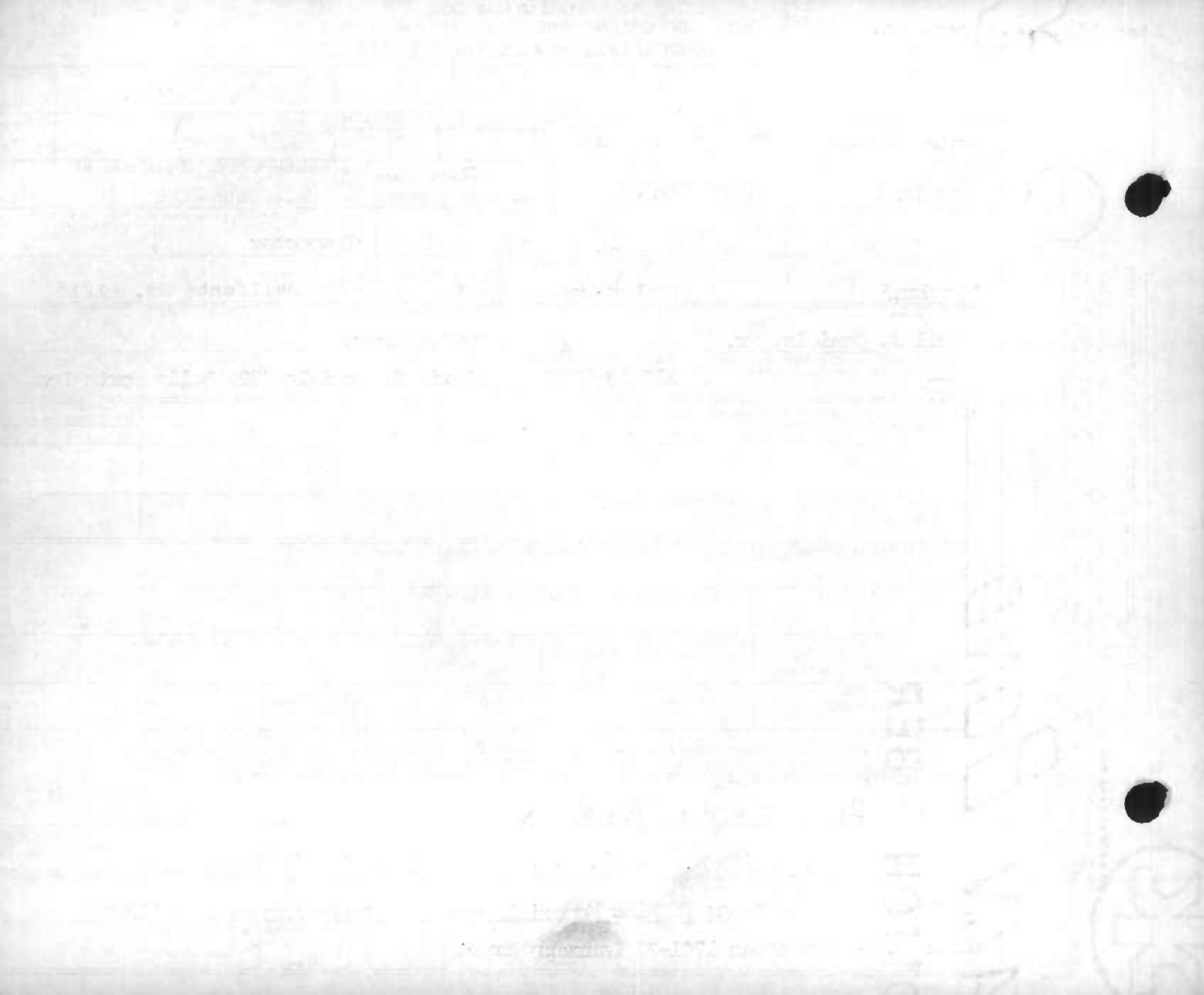
99

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |                  |  |  |   |  | REG. NO.  |  |
|--|-------------------------|---|--|---|------------------|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KARL E. DANIELS SR.</b>   |                         |   |  |   |                  |  |  |   |  | 2b. DATE - KNOWN OF DEATH MATED <b>5-25-84</b> 19 |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>28</b> YEAR <b>35</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>48</b> DAYS <b>48</b> HOURS <b>48</b> MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD <b>5-25-84</b> 19   |  | 2d. HOUR <b>5:33P</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                          |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Co. General Hospital</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4729 Bellforte Rd. 21208</b>                              |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Cecil J. Daniels, Sr.</b> MIDDLE <b>Sr.</b> LAST   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Evelyn</b> MIDDLE <b>Brown</b> LAST  |                  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)  |                         |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-30-9222</b>  |                  | 17. INFORMANT ADDRESS<br><b>Deloris S. Daniels-4729 Belle Forte Road</b>                     |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |                         |   |  |   |                  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).  |                         |   |  |   |                  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |                  |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                         |   |  |   |                  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Margarete De Krell</b>   |                         |   |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b> MEDICAL EXAMINER   |                  |  |  | DATE SIGNED <b>5-26-84</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |                         |   |  | ADDRESS <b>111 Penn Street</b>  |                  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>5-30-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |                  | 23d. LOCATION<br>CITY OR TOWN <b>RANDALLSTOWN</b> COUNTY <b>MARYLAND</b> STATE               |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>James A. Morton &amp; Sons 1701-31 Laurens Street</b>   |                         |   |  | 25b. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1984</b>   |                  | 25a. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                  |  |   |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

12#

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**ROBERT Leroy DANKMEYER**

2a. DATE OF DEATH MONTH DAY YEAR  
**5 04 '84**

2b. HOUR  
**6:20A M**

3. SEX  
**MALE**

4. RACE  
**White**

5. DATE OF BIRTH MONTH DAY YEAR  
**1-22-20**

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.  
**64**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Balto. Md.**

7b. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**BALTIMORE COUNTY** MD.

10. CITY OR TOWN OF DEATH  
**TOWSON**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
**GBMC-6701 N. CHARLES ST.**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Patapsco & B&O R.R. Retired**

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE  
**Md.**

13b. COUNTY  
**Balto.**

13c. CITY OR TOWN  
**Baltimore**

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE  
**8615 Old Harford Rd. -21234**

14. FATHER'S NAME FIRST MIDDLE LAST  
**Louis Dankmeyer**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Lara Maguire**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES)  
**Yes**

16b. SOCIAL SECURITY NO.  
**214-14-9045**

17. INFORMANT ADDRESS  
**Mrs. Florence M. Dankmeyer Balto. Md. 21234**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**RESPIRATORY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1629

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

**METASTASTIC CARCINOMA OF LUNG**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **4/28**, 19 **84**, to **5/04**, 19 **84**, that (I) (we) last saw the deceased alive on **5/04**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
**BC Williamson M.D.**

22c. DATE SIGNED  
**5/04/84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**B.C. WILLIAMSON, M.D.**

22e. ADDRESS  
**GBMC-6701 N. CHARLES ST.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

23b. DATE  
**5-7-84**

23c. NAME OF CEMETERY OR CREMATORY  
**Parkwood Cemetery**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**Balto. Md.**

24. FUNERAL DIRECTOR NAME ADDRESS  
**John C. Miller Inc-6415 Belair Rd. -21206**

25a. DATE REC'D. BY REGISTRAR  
**MAY 8 1984**

25b. REGISTRAR'S SIGNATURE  
**John Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| Stella  |  | May 7, 1984   |  | 8:07P <sub>M</sub>  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |
| F   |  | W   |  | 10/7/15   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| PA.   |  | USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| ROSSVILLE   |  | FRANKLIN SER.   |  | HSWE  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| MD  |  | BALTO   |  | ESSEX   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 13d. STREET ADDRESS / ZIP CODE  |  |
| ANDREW  |  | MONCHKA   |  | PEARL   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |
| NO  |  | 195-10-2165   |  | JOSEPH DASHKIEWICH  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 7855  |  | Cardiogenic Shock   |  |   |  |
| IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.   |  | (b)   |  |   |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
|   |  | (c)   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from May 6, 1984, to May 7, 1984, that (we) lost<br>saw the deceased alive on May 7, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above. (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Allan Gitman  |  | 22c. DATE SIGNED<br>5/7/84  |  |
| 22b. SIGNATURE<br>Allan Gitman  |  | 22c. DATE SIGNED<br>5/7/84  |  | 22d. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| BURIAL  |  | 5/10/84   |  | POLISH NATL. HOLY CROSS   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24. FUNERAL DIRECTOR<br>ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| J.S. CONNELLY   |  | 300 MACE  |  | MAY 14 1984   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |

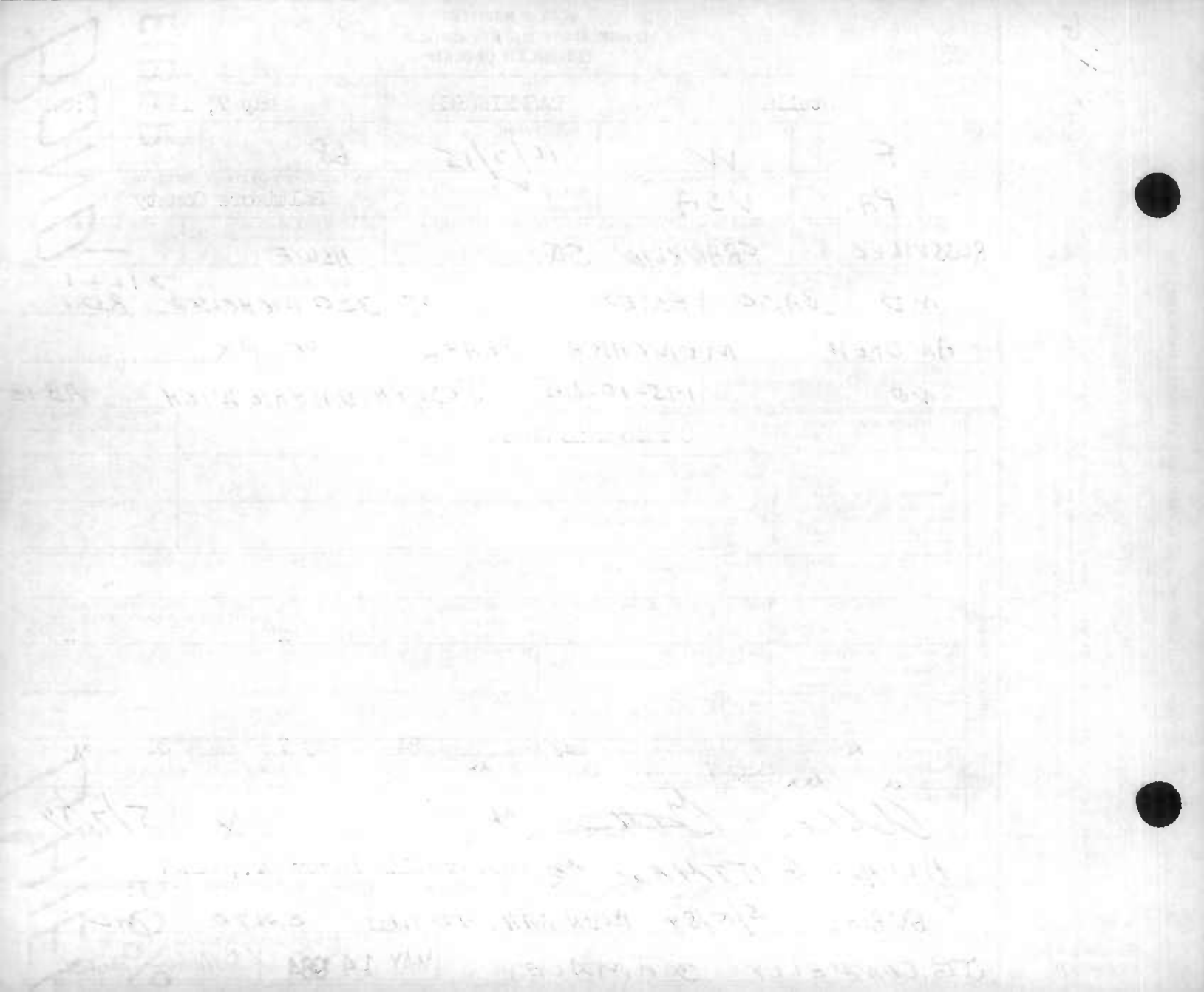
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 1 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |   |  |  |
|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JACOB JAMES DAVENPORT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/1/84</b> |   |   | 2b. HOUR<br><b>7:56 AM</b>  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 29 1900</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>83</b>                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Va. Elec. &amp; Power Co.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>21162</b>   |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Davenport</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lily Dobbins</b>  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>224-05-2516</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>James F. Davenport Sr. 3825 Gambrill Rd. White Marsh, Md. 21162</b>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN TUMOR</b><br><b>2396</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/84</b> , to <b>3/1/84</b> , that (I) (we) lost saw the deceased alive on <b>4/27/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>K.R. Faulkner MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Kenneth Faulkner</b>   |  |  |  | 22e. ADDRESS<br><b>Dulles, VA Road - Towson, Md</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-5-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Penninsula Mem.Pk.Cem. Newport News, Virginia</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hessah JH</b>   |  |  |  | 25. DATE RECD. BY REGISTRAR<br><b>21236 MAY 3 1984</b>  |   | 25. REGISTRAR'S SIGNATURE<br><b>J. H. Dobbins</b>                   |  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_.

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ARMY & NAVY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                           |   |  |  |  | REG. NO.  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|---|---|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William M DAVENPORT</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>9</b> YEAR <b>84</b>                           |   |  |  |  | 2b. HOUR<br><b>M</b>  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>4</b> YEAR <b>1898</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> DAYS <b>HOURS</b> MIN. |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. <b>XXX</b><br>MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto., City</b> |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>KINGSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7127 Mt. Vista Rd. 21087</b> |  |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Police Officer</b>                                  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto., City</b> |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>7127 Mt. Vista Rd. 21087</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7127 Mt. Vista Rd. 21087</b>       |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Mary</b> MIDDLE <b>Elizabeth</b> LAST <b>Ambrose</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Elizabeth</b> LAST <b>Ambrose</b> |   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-26-3576</b> |  |  |  |  |
| 17. INFORMANT<br><b>Barbara Fowble</b>  |  |  |  |  | 17. ADDRESS<br><b>7127 Mt. Vista Rd. Kingsville, Md. 21087</b>                            |   |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>END STAGE CARDIOMYOPATHY</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>RENAL FAILURE</b>  |  |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22. I certify that (1) this decedent attended the deceased from <b>FEB 17</b> 19 <b>84</b> , to <b>MARCH 1</b> 19 <b>84</b> , that (2) <del>the</del> last saw the deceased alive on <b>MARCH 1</b> 19 <b>84</b> , and that in my <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.) |  |  |  |  |   |   |  |  |  | 22c. DATE SIGNED<br><b>5/11/84</b>  |  |  |  |  |  |  |  |  |  |
| 23a. SIGNATURE<br><b>Roy H. Phillips</b>  |  |  |  |  | 23b. ADDRESS<br><b>1716 Harford Rd. Fallston Md 21047</b>                                 |   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  |  |  |  |  |  |  |  |  |
| 23d. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |  |  |  | 23e. DATE<br><b>5-12-84</b>   |   |  |  |  | 23f. LOCATION<br>CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Lassahn Funeral Home</b>  |  |  |  |  | 24. ADDRESS<br><b>1401 Belair Rd. BALTO. MD. 21236</b>                                    |   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>  |  |  |  |  |  |  |  |  |  |
| 25. REGISTRAR'S SIGNATURE<br><b>Juan Davidson-Rodriguez</b>   |  |  |  |  |   |   |  |  |  |   |  |  |  |  |  |  |  |  |  |

BP

RECEIVED  
MAY 1 1964



TO: Mr. J. Edgar Hoover  
FROM: Mr. [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

COPIES  
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MAILED  
MAY 1 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 1 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                   |   |   |  |   |  |  |
|--|--|--|---|---|-------------------|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ruby C. Davis</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 28 84</b>                 |   |                   | 2b. HOUR<br><b>M</b>  |   |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 9 1915</b>   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7009 Falt Avenue</b> |   |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>          |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |  | 13b. COUNTY<br><b>Baltimore</b>                                       |   | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7009 Falt Avenue 21224</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Combs</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Linda Preston</b> |   |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>404-05-4038</b> |  |
| 17. INFORMANT<br><b>Donna Nuedling</b>   |  |  | ADDRESS<br><b>7315 School Ave. Balto., MD. 21222</b>                  |   |                   |   |   |  |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic adenocarcinoma of L. Kidney**

**1890**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

**Chronic Renal Disease. Uremia**

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Diabetes Mellitus.**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>5/2/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 3-83</b> 19____, to <b>5/2/84</b> 19____, that (I) (we) last saw the deceased alive on <b>5/2/84</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |

|  |  |                       |  |  |  |                                    |  |
|--|--|-----------------------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE<br><b>Enrique A. Herrera</b>                              |  | DEGREE<br><b>M.D.</b> |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/29/84</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Enrique A. Herrera, M.D.</b> |  |                       |  | 22e. ADDRESS<br><b>1001 Dundalk Avenue, 21224.</b>   |  |                                    |  |

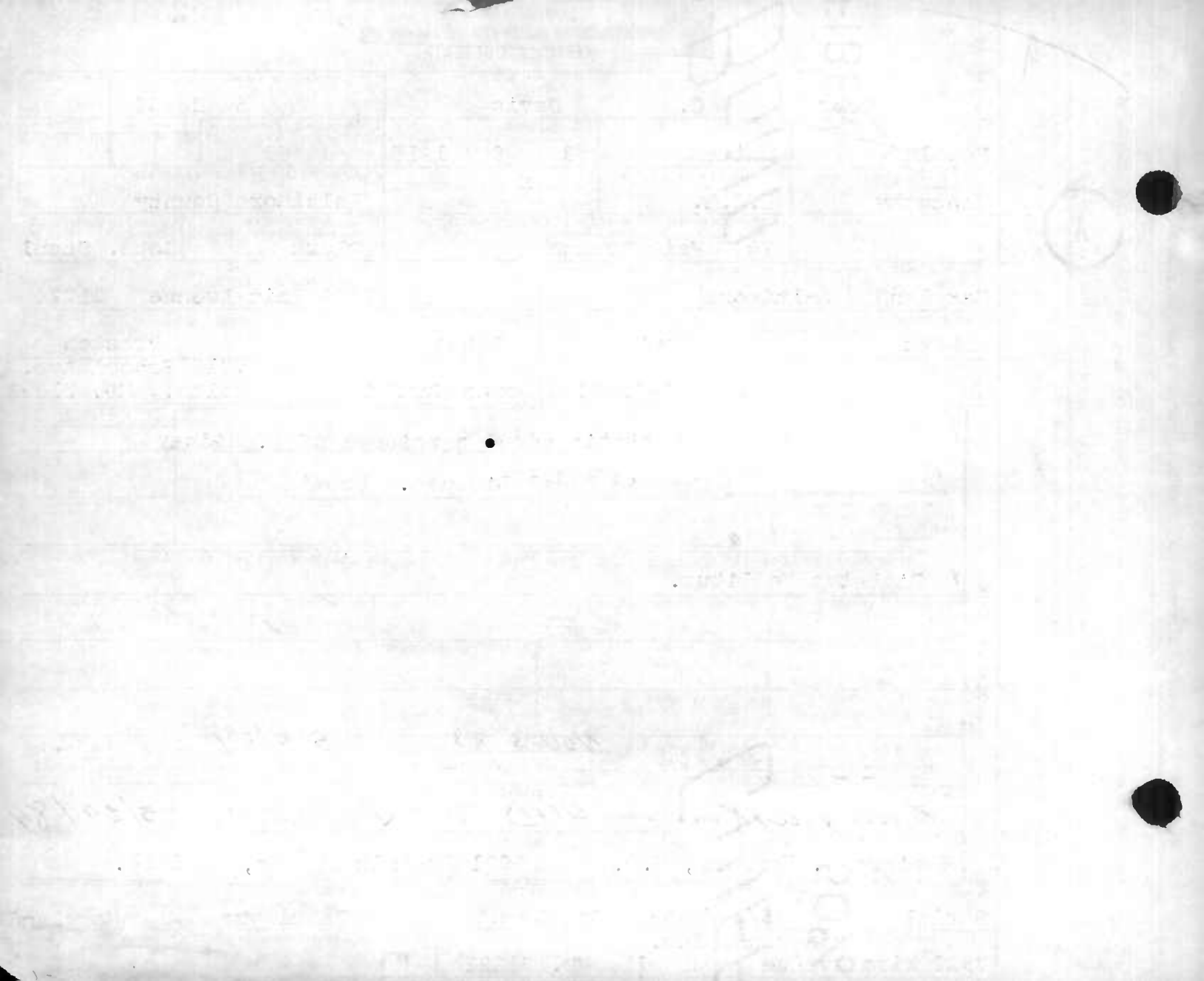
|   |  |                               |  |   |  |   |  |
|---|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>5/30/1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
|---|--|-------------------------------|--|---|--|---|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |
|--|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Herbert Madison Day  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 13, 1984 |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 13, 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Woodlawn   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1903 Greengage Rd. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret-Sec & Treas.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Elite Laundry   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Woodlawn   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br>1903 Greengage Rd. 21207  |  |   |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alvey Day   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Tibbles   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW 1 215-03-5026  |   | 17. INFORMANT<br>Baltimore, MD 21207<br>Mrs. Mildred D. White 1903 Greengage Rd.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic Renal failure<br>4049 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive CVD<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years<br>years |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13 to 5/13, 1984, that (I) (we) last saw the deceased alive on 5/13, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br>James Nolan   |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>5/15/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. James Nolan  |  | 22e. ADDRESS<br>1 Mallow Hill Rd. 21229   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5/18/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Kriders Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westminster Carroll MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd. Randallstown, MD 21133  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1984  |  |  |  |

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Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into sections or paragraphs, with some lines being underlined. There are also some small, illegible markings and symbols scattered throughout the page.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |                              |  |
|--|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gloria Jean Declercq</b>                   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 14, 1984</b> |  | 2b. HOUR<br><b>8:34 a.m.</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 11, 1945</b>  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>39</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |                              |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Middle River</b>   |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? Ryan</b>                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eleanor Duvall</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>    |  | 16b. SOCIAL SECURITY NO.<br><b>054 36 3574</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Vernon R. Declercq Sr. (same)</b>   |                              |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1: DEATH WAS CAUSED BY:

**4100**  
IMMEDIATE CAUSE (a)

**Myocardial infarction, acute anterior**

**anterolateral and septum**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF  
(b)  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

**Arteriosclerotic cardiovascular disease with  
thrombosis of left anterior descending**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>May 6</b> , 19 <b>84</b> , to <b>May 14</b> , 19 <b>84</b> , that (x) (we) last<br>saw the deceased alive on <b>May 14</b> , 19 <b>84</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (x) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert H. Wiedefeld Jr. M.D.</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>May 14, 1984</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert H. Wiedefeld Jr. M.D.</b>   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>               |  |   |  |   |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>5/17/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem., Arlington Fairfax Virginia</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdinski Funeral Home</b>        |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1984</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>   |  |                             |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a copy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical certificate must be filed at the same time as this certificate.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR                      |  |
| MILDRED   |  |  |  |  |  | DENNIS   |  | 5 19 84 7:10 PM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                          |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.        |  |
| Female  |  | BLACK  |  | 12 17 21   |  | 63 YRS.  |  |  |  |
| 7a. BIRTHPLACE (COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |  |  |
| Gmd.  |  | U.S.A.   |  |  |  | Baltimore Co. MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |  |  |
| Baltimore   |  | STELLA MARIS HOSPICE - Dulles Valley Rd. 2300  |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |
| File Clerk  |  | Ind. Nat Bank  |  |  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS                                      |  |  |  |
| Maryland  |  |  |  | BALTO.   |  | 611 N. Bentlev St 21216                                  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16. ADDRESS  |  |  |  |  |  |
| Charles   |  | Dennis   |  | Kosette Collins  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 16c. INFORMANT   |  | 16d. ADDRESS   |  |  |  |
| NO  |  | 21546-1839   |  | Mrs. Gladys Tyner  |  | 4011 Springdale Ave 21207                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON - METASTATIC.   |  |  |  |  |  |  |  |  |  |
| 1539 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |
| Ureteral & Intestinal Obstruction & Nephrostomy   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
|   |  | 19   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-16-84 to 5-19-84, that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE DEGREE   |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |
| Kendall R. Faulkner MD  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  | 22e. ADDRESS   |  |
| Kendall R. Faulkner MD  |  |  |  |  |  |  |  | Stella Maris 2300 Dulles Valley Rd -                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (CIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                  |  |  |  |
| Burial  |  | 5-25-84  |  | Arbutus Mem. Park  |  | BALTO. Co. Gmd.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                            |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Joseph L. Russ 2222 W. North Ave  |  |  |  |  |  | MAY 22 1984  |  | Julia Davidson-Randall   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE THIS CERTIFICATE WITH THE STATE REGISTRAR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |   |   |   |   |  |   |  | REG. NO. |  |
|--|-------------------------|---|---|---|---|---|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HOWARD WILLIAM DESPEAUX</b>  |                         |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>5/23 1984</b>                                   |  | 2b. HOUR<br>M<br><b>11</b>  |  |          |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-14-1899</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>84</b> YRS.        | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5/23 1984</b>                                  |  | 7d. HOUR<br>M<br><b>11</b>  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>201 Rodgers Forge Road</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Commercial Artist</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sun Paper</b>                               |  |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |   |   |   |   |  |   |  |          |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>201 Rodgers Forge Road 21212</b>                          |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Howard Despeaux</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Kuhn</b>  |   |   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>WWI Yes</b>  |                         | (IF YES, GIVE WAR OR DATES)<br><b>WWI</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>217-12-7660</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. Edward Despeaux 23 Wonderview Ct. 21093</b>                     |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292 ASCVD</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 years</b>                     |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |   |   |   |   |  |   |  |          |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |  |   |  |          |  |
| ACTUAL SIGNATURE<br><b>Stanley Z. Felsenberg MD.</b>   |                         |   | TITLE (SPECIFY)<br><b>MD.</b>                               |   | MEDICAL EXAMINER  |   | DATE SIGNED<br><b>5/27/84</b>                                      |   |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>STANLEY Z. Felsenberg MD.</b>   |                         |   | ADDRESS<br><b>11 E. Chase St. 21202</b>                     |   |   |   |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |                         | 23b. DATE<br><b>5-29-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>  |                         |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles W. Randall</b>                             |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |   |
|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OLIVIA DEUTSCH</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-25-84</b>   |  | 2b. HOUR<br><b>9:35</b> M                                       |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 16, 1895</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BEL AIR</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BEL AIR CONVALESCENT CENTER</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b>  |   |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>BALTO. HARFORD</b>  | 13c. CITY OR TOWN<br><b>BEL AIR</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            | 13e. STREET ADDRESS<br><b>113C DONZEN DR. #21014</b>            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ELLIOT LEIPNER</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MATILDA BROWN</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   | 17. INFORMANT<br><b>MR. ELLIOT DEUTSCH</b><br><b>731 BALTO. PIKE BEL AIR, MD 21014</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                         |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/26</b> 19 <b>83</b> , to <b>5/28</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>8/26</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (they) did not view the body after death, view this body after death.) |   |   |  |   |
| 22b. SIGNATURE<br><b>Andrew Nowakowski MD</b>  | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  | 22c. DATE SIGNED<br><b>5-25-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDREW NOWAKOWSKI MD</b>   | 22e. ADDRESS<br><b>125 N. MAIN ST BEL AIR, MD</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>REMOVAL/BURIAL  | 23b. DATE<br><b>MAY 27, 1984</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WELLWOOD ASSOC. INC.</b>   | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>PINELAWN BABYLON LI, NY</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 31 1984</b>  |  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Handall</b>   |  |   |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |   |  |                                    |  |   |  |
|---|--|---|--|--|---|--|------------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anna</b>  |  | FIRST<br><b>DICHIARA</b>  |  | LAST<br><b>DICHIARA</b>  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 27, 1984</b>                              |                                    | 2b. HOUR<br><b>10:30A<sub>M</sub></b>                      |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>CAU</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 3 05</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                                     |                                    | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County,</b> MD.                 |                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOS.</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE WORK, LAST 100% OF WORKING LIFE)<br><b>SEAMSTRESS</b> |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>       |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b> |  |   |  |  | 13b. COUNTY<br><b>BALTO.</b>                      |  | 13c. CITY OR TOWN<br><b>BALTO.</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>NICHOLAS MARZIALI</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>MARIA CIRABENI</b> |  |                                    |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                  |  | 16b. SOCIAL SECURITY NO.<br><b>212/28/2576</b>  |  | 17. INFORMANT ADDRESS<br><b>JOHN DICHIARA 3811 MAYBERRY AVE</b>  |   |  |                                    |  |   |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest-Acute Myocardial Infarction</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>May 26, 1984</b> to <b>May 27, 1984</b> , that (1) (we) last saw the deceased alive on <b>May 27, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (and I) did not view the body after death, so state.) |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Chris Berchemann</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/27/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Chris Berchemann</b>   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                |  |  |  |  |  |

|  |  |                                   |  |  |  |   |  |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>ENTOMBMENT</b> |  | 23b. DATE<br><b>5/30/84</b>       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b> |  | 23d. LOCATION<br><b>WOODLAWN/ Md.</b> COUNTY STATE          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Frank D. Della Roca</b>     |  | ADDRESS<br><b>372 S. High St.</b> |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 31 1984</b>      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LIBRARY

1950 3 12 10 30 AM

WASHINGTON NATIONAL MUSEUM

ENTRANCE

WASHINGTON NATIONAL MUSEUM

515/28/2245 JOHN DEANARD 301 MAYHURST AVE

WOLFE/VA. 10.

2/30/84

ENTRANCE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |   |   |  |  |   |   |       | REG. NO.  |  |                    |
|--|------------------|--|---|---|--|--|---|---|-------|---|--|--------------------|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>Aline E. Dietrich   |                  |  |   |   |  |  |   |   |       | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>5/9/84 19 |  | 2b. HOUR<br>M<br>P |
| 3. SEX<br>FEMALE   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 20 08  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>76 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE PRONOUNCED DEAD<br>5/9/84 19                                  |   | 24. HOUR<br>M<br>P  |       | 25. HOUR<br>M<br>P                                |  |                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County               |   |   | MD.   |   |  |                    |
| 10. CITY OR TOWN OF DEATH<br>Woodlawn  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2000 Summit Ave. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Soc. Security                                  |       |   |  |                    |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY<br>Balt  | 13c. CITY OR TOWN<br>Woodlawn                 |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2000 Summit Ave. |   | 21207 |   |  |                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Waldemar F. Dieterich  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice McCair   |  |  |   | ADDRESS 6500 Gilmore St.  |       |   |  |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-12-4350   |   | 17. INFORMANT<br>Mr. Charles G. Nelson Balto., Md.  |  |  |   | 21207   |       |   |  |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |  |   |   |  |  |   |   |       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |   |   |  |  |   |   |       |   |  |                    |
| 19a. DATE OF OPERATION   |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |   |  |                    |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |   |       |   |  |                    |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |       |   |  |                    |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |  |  |   |   |       |   |  |                    |
| ACTUAL SIGNATURE<br>Gregory R. Kauffman, M.D.  |                  |  |   | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  |   | DATE SIGNED<br>5/10/84  |       |   |  |                    |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |                  |  |   | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |  |   |   |       |   |  |                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |                  | 23b. DATE<br>5/10/84   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |       |   |  |                    |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |                  |  |   | ADDRESS<br>Balto., Md.  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br>MAY 15 1984   |       |   |  |                    |
|  |                  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall  |  |  |   |   |       |   |  |                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 7a. DATE OF DEATH  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | MONTH DAY YEAR   |  |   |  |
| FIRST MIDDLE LAST  |  |  |  | 7b. HOUR   |  |   |  |
| SALVATORE T DIFATTA  |  |  |  | 5 14 84 1:17p M  |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | White  |  | MONTH DAY YEAR   |  | IF UNDER 1 YEAR   |  |
|  |  |  |  | Feb. 1, 1903   |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland   |  | U.S.A.   |  |  |  | BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| TOWSON   |  | G.B.M.C.   |  | Ret. Farmer  |  |   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  |   |  |
| Maryland   |  |  |  | Baltimore  |  |   |  |
| 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |   |  |
| Parkville  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST  |  |   |  |
| Salvatore DiFatta  |  |  |  | Teresa Matssa  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |
| No   |  | 213-54-4438  |  | Anna M. DiFatta 7803 Oak Ave. 21234  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION  |  |  |  |  |  |   |  |
| 4100   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |
| (b) ATHEROSCLEROTIC CORONARY ARTERY DISEASE  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |
| (c)  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
|  |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |
|  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14, 19 84, to 5/14, 19 84, that (I) (we) lost saw the deceased alive on 5/14, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| Robert A. Palermo MD   |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |
| ROBERT A. PALERMO, M.D.  |  |  |  | 6701 NORTH CHARLES STREET, BALTIMORE MD 21204  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Entombment   |  | May 17 1984  |  | Dulaney Valley Cem.  |  | Cockeysville Maryland   |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  |
| NAME ADDRESS   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Leonard J. Ruck, Inc. Baltimore, Maryland  |  |  |  | MAY 16 1984  |  |   |  |



188 J. Ave. Leonard J. Luck, Inc. Baltimore, Maryland  
Cockeysville, Maryland  
Telephone No. 17 1884 Baltimore Valley Com.

213-24-1438 Anna M. Shaffer 7803 Oak Ave. 21224  
Baltimore  
21224

21224 7803 Oak Ave. 21224  
Baltimore  
21224

U.S.N.O.  
188 J. Ave.

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Feb. 1, 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR  |  |   |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |  |  |   |   | REG. NO.   |                                |  |  |  |
|--|--|---|--|--|--|--|--|---|---|--|--------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |  | 2a. DATE OF DEATH  |  |  |   |   | 2b. HOUR   |                                |  |  |  |
| ELLEN LEACH DIGGS  |  |   |  |  | May 5, 1984  |  |  |   |   | 7:55A <sub>M</sub>   |                                |  |  |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                   |  | IF UNDER 1 YEAR   |   | IF UNDER 24 HRS  |                                |  |  |  |
| Female   |  | White   |  | Aug. 22, 1893  |  | 90   |  | MONTHS  |   | DAYS   |                                | HOURS MIN.                                   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                              |  |   |   |  |                                |  |  |  |
| Maryland   |  | U.S.A.  |  |  |  | Baltimore County, MD.  |  |   |   |  |                                |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |                                |  |  |  |
| 21234  |  | 1701 Kenoway Road 21234   |  |  |  | Secretary  |  | Investment  |   |  |                                |  |  |  |
| 13a. STATE   |  |   |  |  | 13b. CITY OR TOWN  |  | 13c. CITY OR TOWN                                  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE |  |  |  |
| Maryland   |  |   |  |  | Baltimore  |  | 21234  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1701 Kenoway Road 21234        |  |  |  |
| 14 FATHER'S NAME   |  |   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |   |  |                                |  |  |  |
| Charles W. Burton, Sr.   |  |   |  |  | Eurith Leach   |  |  |   |   |  |                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                              |  | 17. INFORMANT ADDRESS                              |   |   |  |                                |  |  |  |
| No   |  |   |  |  | -----  |  | 214-03-0621 Dorothy B. King 1701 Kenoway Rd. 21234 |   |   |  |                                |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASA AND AF. C.H.F.</u><br><u>4029</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |  |  |   |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |  |   |  |  |  |  |  |   |   |  |                                |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                |  |  |  |
|  |  |   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) |   |  |                                |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> 19 <u>84</u> to <u>5/5</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>5/30</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |   |  |  |  |  |  |   |   |  |                                |  |  |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |   |  |                                |  |  |  |
| <u>Donald W. Mintzer, M.D.</u>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | <u>5/5/84</u>   |   |  |                                |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |   |   |  |                                |  |  |  |
| Donald W. Mintzer, M.D.  |  |   |  | 3009 Evergreen Avenue  |  |  |  | 254-5227  |   |  |                                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                               |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |                                |  |  |  |
| Burial   |  |   |  | May 8, '84   |  | Druid Ridge Cemetery   |  |   |   | Baltimore, MD  |                                |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |                                |  |  |  |
| William E. Johnson   |  |   |  | 8521 Loch Raven Blvd.  |  |  |  | MAY 7 1984 <u>Julia Davidson-Randall</u>                                      |   |  |                                |  |  |  |

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Item #1 Film G 592

FOR  
1- STATE  
REGISTRAR

6/7/84 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 2 2

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>FRANK L. DILLFELDER  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>05 21 '84   |  | 2b. HOUR<br>2:45 P.M.   |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>February 4, 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sheetmetal   |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 13e. STREET ADDRESS / ZIP CODE<br>1200 Dulaney Va-ley Rd. 21204   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>Michael Dillfelder   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie A. Reichter   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-07-5904  |  | 17. INFORMANT ADDRESS<br>Anna M. Dillfelder -Same as #13e   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7070 CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) MULTIPLE DICUBITUS ULCERS   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/4, 19 84, to 5/21, 19 84, that (I) (we) lost<br>saw the deceased alive on 5/21, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><i>Timothy Herlihy M.D.</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>5/21/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TIMOTHY HERLIHY, M.D.  |  |   |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES STREET 21204   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5-25-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium, Baltimore, Maryland   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 23 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

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February 1997

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### Interpretation

Благодарю

normal position

12000 Delaney Ave. - 1st Fl. - 21204

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single

• **A**

referred to

575-07-2504

John M. Dillinger - born 22 1936

Index

United States

1550 York St.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. OR, IF DESIRED, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR AND PAGE 4 TO THE CHIEF MEDICAL EXAMINER. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |   |   |  |  |                          |   |  | REG. NO.                                     |  |
|--|------------------|--|---|---|--|--|--------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSEPH Huff DOBSON  |                  |  |   |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br>MONTH DAY YEAR<br>5 25 19 84                    |                          | 2b. HOUR<br>M<br>3:21 AM  |  |  |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 7 23 61 YRS.   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5 25 19 84 |  | 2d. HOUR<br>M<br>3:21 AM |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |                          |   |  |  |  |
| 11. CITY OR TOWN OF DEATH<br>Towson  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hosp. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor          |                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |   |   |  |  |                          |   |  |  |  |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Cockeysville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                          | 13e. STREET ADDRESS<br>10020 Hillgreen Circle 21030                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph F. Dobson   |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Joyce Zola Huff  |  |  |                          |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |                  | (IF YES, GIVE WAR OR DATES)<br>WWII  |   | 16b. SOCIAL SECURITY NO.<br>216-16-3459   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Susanne M. Dobson Balto., Md.                       |                          |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                  |  |   |   |  |  |                          |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |                          |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                          |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |                  |  |   |   |  |  |                          |   |  |  |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.  |                  |  |   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |                          | DATE SIGNED<br>5-25-84  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |                  |  |   | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |  |                          |   |  |  |  |
| 23a. BURIAL (CREMATION) REMOVAL (SPECIFY)<br>Removal   |                  | 23b. DATE<br>5/25/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gardens   |  |  |                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium, Balto., Md.                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |                  |  |   | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 1 1984  |                          | 25b. REGISTRAR'S SIGNATURE<br>Dobson  |  |  |  |

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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1911

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 2 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward R. DOLAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 21, 1984</b> |   |  | 2b. HOUR<br><b>2:45P M</b>  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 18 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>77</b>                                |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE IF WORK FORMER OR WORKING LIFE)<br><b>Assembler</b>              |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Middle River</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>19 Dihedral Dr. 21220</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Moran</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Dolan</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>233 16 4393</b>  |  | 17. INFORMANT<br><b>Ella C. Dolan, Wife</b>   |  | ADDRESS<br><b>Same</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis, Chronic Renal Failure</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>April 12, 1984</b> to <b>May 21, 1984</b> , that (we) last saw the deceased alive on <b>May 21, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death.  |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><i>James P. de la Flor</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>5-21-84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James P. de la Flor, MD</b>   |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>5/24/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                         |   |
| 24. FUNERAL DIRECTOR<br><i>Bruzdzinski Funeral Home</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>24 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>La Davidson</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medicolegal autopsy should be considered and done.)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOANN A DOREMUS</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>5-27-84</b>   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Dec. 6, 1927</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Detroit, Michigan</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital 21204</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. CITY OR TOWN<br><b>A.A. Co. Severna Park</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Law</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann Kennedy</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>379-22-5057</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Donald P. Doremus 678 Kensington Ave. West 21146</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>XXXX IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST.</b>             |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |  |  |   |  |
| (b) <b>METASTATIC CANCER OF PANCREAS.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>4-11-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>EXPLORATION</b>  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-27-84</b> to <b>5-27-84</b> ; that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>DR. ROBERTO FERRER</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5-27-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. ROBERTO FERRER</b>  |  |   |  | 22e. ADDRESS<br><b>40 ST. JOSEPH HOSP., TOWSON, MD.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>May 28, '84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery Baltimore, MD</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1984</b>  |  |   |  |
| ADDRESS<br><b>8521 Loch Raven Blvd.</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |   |   |  |
|--|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARCELLA C. DRUSANO   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 18 1984                     |   |   | 2b. HOUR<br>10:20 AM  |   |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 23 1910   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VALLEY VIEW NURSING HOME |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TELEPHONE OPR.              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>TELEPHONE CO.  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>COCKEYSVILLE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>10631 ANGLO HILL RD. 21030  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>217-05-1824   |  | 17. INFORMANT<br>ADDRESS<br>DR. GEO. DRUSANO (SON) SAME ADDRESS   |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>old stroke</u><br><u>2765</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>dehydration</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |   |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/83</u> to <u>5/18/84</u> , that (I) <u>was</u> last saw the deceased alive on <u>5/16/84</u> 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did not) view the body after death.  |  |   |  |   |   |   |   |   | 22b. DATE SIGNED<br>5/21/84                  |
| 22a. SIGNATURE<br><u>Dr. Vuong Vu Nguyen</u>   |  |   |  | 22b. PHYSICIAN'S NAME<br>DR. VUONG VU NGUYEN  |   |   |   | 22c. ADDRESS<br>6331 Belair Rd.   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>5/22/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD. |   |  |
| 24. FUNERAL HOME<br>SCHIMUNEK FUNERAL HOME, INC.<br>3331 Brehms Lane, Balto. Md. 21213   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 22 1984  |   | 25b. REGISTRAR'S SIGNATURE  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a medical certificate, see page 4 of this form.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "yes" in item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR   |  |  |  |
| Mary Leona DuBay  |  |  |  | 05 13 84 7:50 AM   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female  |  | White  |  | 09 13 1892   |  | 91 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore County MD  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Randallstown  |  | Old Court Nursing Center   |  | Homemaker  |  | ---  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| Maryland  |  | Baltimore  |  | Catonsville  |  | 5113 Edmondson Avenue, 21228                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| Victor Stoffel  |  |  |  | Mary Dreves  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| No  |  | 220-68-3479  |  | Frances H. Cahoon 1205 Elmridge Ave, 21229   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>4110</i>  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Coronary insufficiency</i>  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Rheumatoid arthritis, severe</i>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 53</i> , to <i>May 13 84</i> , that (I) (we) lost the deceased alive on <i>May 4 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <i>B Matos M.D.</i>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 5/15/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| Bienvenido R. Matos, M.D.   |  |  |  | 21 Cranbrook Road; Cockeysville, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 05-16-84   |  | Woodlawn Cemetery 21229  |  | Woodlawn Baltimore Maryland                                    |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |  |  | MAY 15 1984 <i>Julia Davidson-Randall</i>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

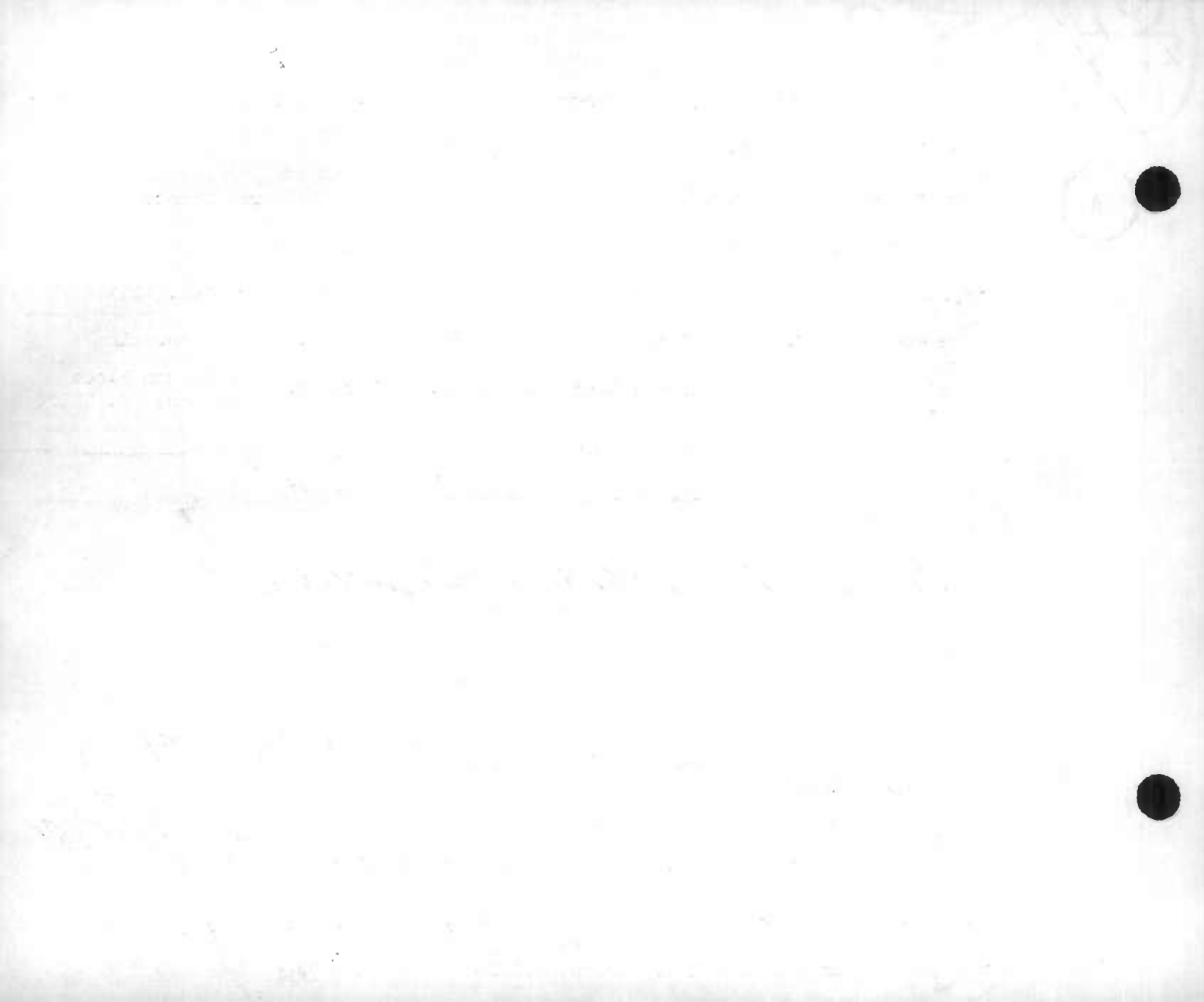
|  |  |  |   |  |  |   |  |  |  |
|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JEANNETTE M. DYOTT</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 18, 1984</b> |  |  | 2b. HOUR<br><b>1:00 A</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>August 1, 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Broadmead - York Rd.</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4106 Glenarm Ave. 21206</b>   |  |
| 14. FATHER'S NAME<br><b>Edward F. Weller</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Julia E. Augustine</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-5665</b>   |   | 17. INFORMANT ADDRESS<br><b>Edward F. Weller, Jr. 1 Smeton Place<br/>Towson, Md. 21204</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) ASCUD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Heart Heart</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Severe Chronic Active Hepatitis</b>  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/1/84</b> 19 <b>81</b> , to <b>5/18</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/1/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Frank J. Sanzaro</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>5/18/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frank J. Sanzaro, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>3313 Papermill Rd., Cockeysville, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-19-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. County Maryland</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  |  |   | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permits. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |                                   | REG. NO.  |  |
|---|--|---|--|---|--|---|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Henry Christian Eckert, Sr.   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 1, 1984   |  |   |                                   | 2b. HOUR<br>6:35 a M                            |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5-4-1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Transfer Business           |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7706 Bluegrass Rd. 21237  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry C. Eckert   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Elizabeth Murphy  |  |   |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>18-7563A   |  | 17. INFORMANT<br>ADDRESS<br>Rosalie A. Eckert, Same as 13e  |  |   |  |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>5789 IMMEDIATE CAUSE (a) Probable Myocardial Infarction; Cardiogenic Shock.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Upper Gastrointestinal Bleed; shock.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Chronic Obstructive Pulmonary Disease.  |  |   |  |   |  |   |  |   |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |   |  |   |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |                                   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 30, 1984, to May 1, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 1, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |   |  |   |  |   |  |   |                                   |   |  |
| 22b. SIGNATURE<br>Jagiello  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>May 1, 1984   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jagiello   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |  |   |  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5-4-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 2 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |                                   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Edith Thomas EDMUNDS</b>  |  |   |  | 2b. HOUR<br><b>10AM</b>   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 2, 1891</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>92</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Garrison</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Garrison Valley Center, Inc.</b>               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Herbert Thomas</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Carrie Munder</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>216-46-1521</b>   |  | 17. INFORMANT <b>Dgthr-in-law</b> ADDRESS<br><b>Ruth L. Holstad, Excelsior, Minnesota 55331</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>hypertension s/p con</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1984</b> to <b>May 31, 1984</b> , that I (we) last saw the deceased alive on <b>May 4, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert Macht MD</b>   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>6/1/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Macht</b>   |  | 22e. ADDRESS<br><b>701 W. Read St</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>6/2/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>STEWART &amp; MOWEN CO., 108 W. North Ave. 21201</b>   |  |   |  | 25. RECEIVED BY (NAME AND ADDRESS) REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |

WILLIAM THOMAS

Oct. 1, 1891

Salisbury County

Garrison Valley Center, Inc.

Salisbury University

Under

Garrison  
Center-Inc.

210-44-1231 From J. Robert, Excelsior, Minnesota 55301

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 3 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Grace E. Edrington</b>  |  |   | 2a. DATE OF DEATH MONTH <b>5</b> DAY <b>17</b> YEAR <b>84</b>   |   | 2b. HOUR <b>7:30 PM</b>  |
| 1. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>2</b> YEAR <b>1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST Joseph Hospital 21204</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  |   | 13b. COUNTY <b>Baltimore</b>  | 13c. CITY OR TOWN <b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b></b> LAST <b>Walker</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mollie</b> MIDDLE <b></b> LAST <b>Walker</b>                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-9580D</b>   |   | 17. INFORMANT ADDRESS<br><b>Wm. Edrington 1714 Edgewood Rd. 21234</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>Diabetes mellitus</b>  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>St. M. de la Monte, MD</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>5/17/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. M. de la Monte</b>  |  | 22e. ADDRESS<br><b>St. Joseph Hospital</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   | 23b. DATE<br><b>5/21/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>A. Alan Seitz, Jr.</b> ADDRESS <b>3818 Roland Avenue 21211</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAY 22 1984 Julia Davidson-Randall</b> |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and 2 should be kept with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP



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PARK F. EGBERT

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 3 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PARK</b>   |  |  | FIRST MIDDLE LAST<br><b>EGBERT</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 14, 1984</b>   |  |  | 2b. HOUR<br><b>1:25 AM</b>   |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>CAUCASIAN</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 10 10</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MANUFACTURE</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN<br><b>ROSEDALE</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>7509 BRIGHTSIDE AVE. 21237</b>  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WALTER R. EGBERT</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BEATRICE E. SLIMMER</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218051528</b>  |  |  | 17. INFORMANT ADDRESS<br><b>DOROTHY EGBERT 7905 BRIGHTSIDE AVE.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ca of the lung with pleural metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe COPD, Aortic Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1984</b> , to <b>May 14, 1984</b> , that (I) (we) lost saw the deceased alive on <b>May 14, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>M. Baker</b>  |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br><b>5/14/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MOHAMED S. BAKEER</b>  |  |  | 22e. ADDRESS<br><b>7621 York Rd. Balto, Md. 21204</b>   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>5/15/84</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEMETREY</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>J. Lewis</b> ADDRESS <b>1211 VACH. CHESCO AVE</b>  |  |  | 25a. DATE RECEIVED BY REGISTRY<br><b>MAY 14 1984</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  |

BP

EGBERT May 14 1984 1:24

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James H. Brown

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 3 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

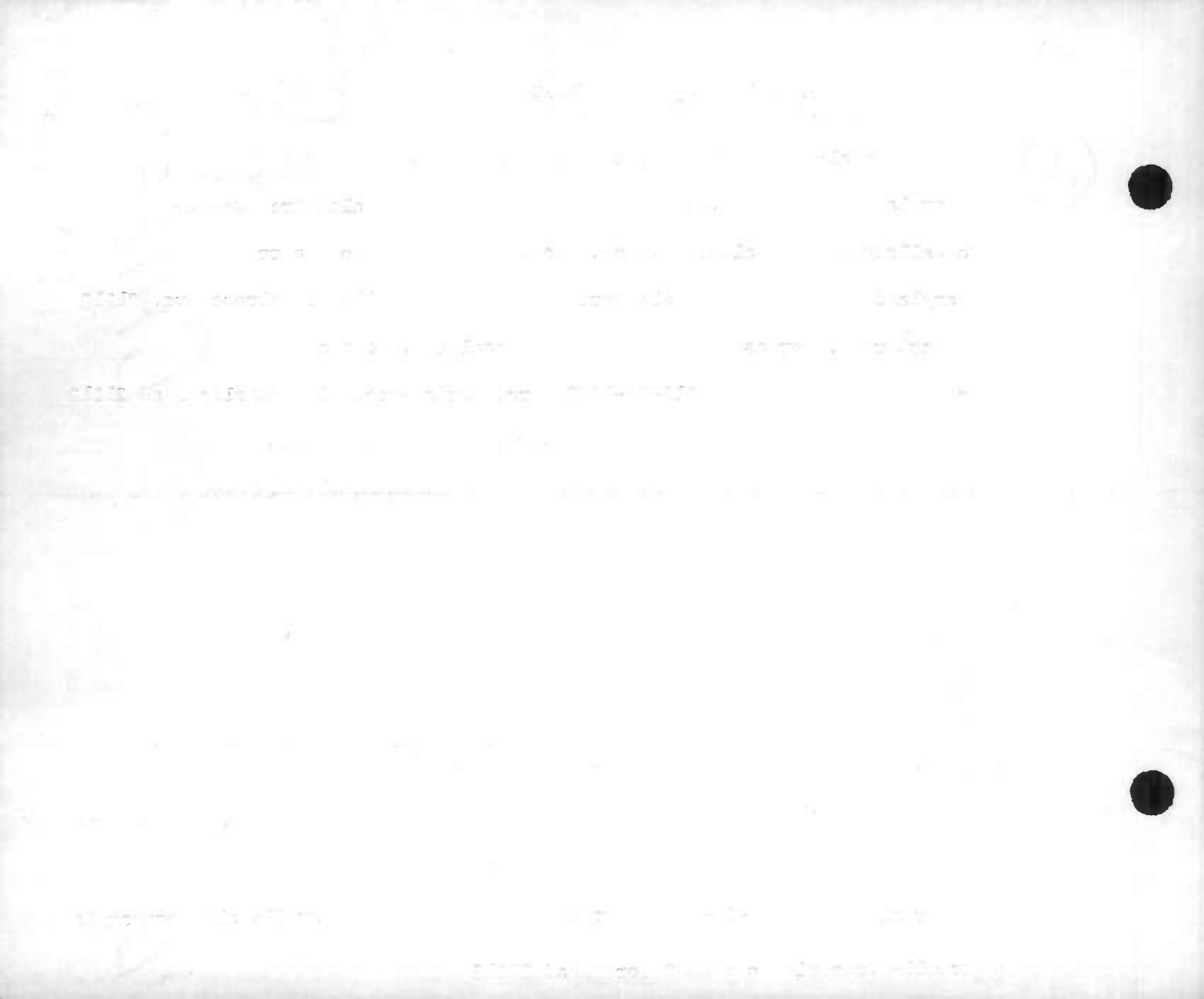
|  |  |   |   |  |  |  |  |   |  |  |  |
|--|--|---|---|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET GORGAS EHRlich</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>24</b> YEAR <b>84</b>  |  |  | 2b. HOUR<br><b>4:50 AM</b>   |  |   |  |  |  |
| 3. SEX<br><b>F Female</b>  |  | 4. RACE<br><b>W White</b>                     |   | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>11</b> YEAR <b>02</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | 8. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |   |  |  |  |
| 13. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  |   | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Gen. Hosp.</b> |  |  | 15a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  |   | 15b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>Maryland</b> 16b. COUNTY <b>BALTIMORE</b>  |  |   | 16c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 16d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   | 16e. STREET ADDRESS / ZIP CODE<br><b>310 E. Melrose Ave. 21212</b>   |  |  |
| 17. FATHER'S NAME<br>FIRST <b>Herbert F.</b> MIDDLE <b>Gorgas</b> LAST <b>Gorgas</b>   |  |   | 18. MOTHER'S MAIDEN NAME<br>FIRST <b>Rosalie E.</b> MIDDLE <b>Hoffman</b> LAST <b>Hoffman</b>   |  |  |  |  |   |  |  |  |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   | 19b. SOCIAL SECURITY NO.<br><b>213-74-1882</b>  |  |  | 19c. INFORMANT ADDRESS<br><b>Mrs. Doris Sheck 624 Anneslie Road 21212</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>4151</b> IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLE PULMONARY EMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                    |  |   |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |   |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-22-84</b> to <b>5-24-84</b> , that (I) (we) last saw the deceased alive on <b>5-24-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. DEPESTRE</b>   |  |   | DEGREE <b>MD</b>  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>5-24-84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. DEPESTRE</b>  |  |   | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSP.</b>   |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>5-26-84</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Pikesville</b> COUNTY <b>Baltimore</b> STATE <b>Maryland</b>                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Road 21212</b>  |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 25 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Jane Davidson</b>   |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signs any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

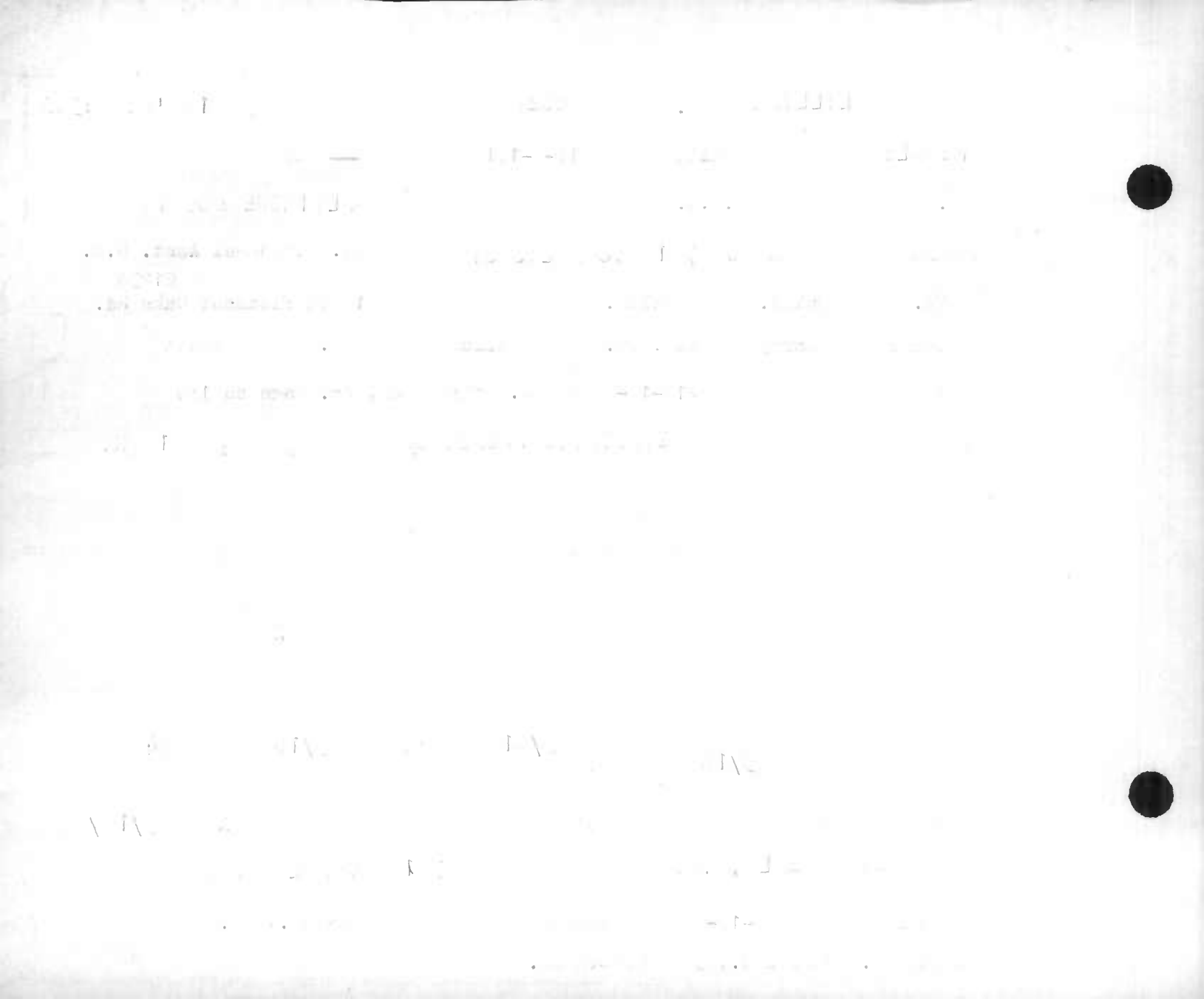
|  |  |   |   |   |  |   |  |   |               |            |                                |
|--|--|---|---|---|--|---|--|---|---------------|------------|--------------------------------|
| 1 - FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST<br>LILLIAN  | MIDDLE<br>M.   | LAST<br>ESER  | 2a. DATE OF DEATH  | MONTH<br>5  | DAY<br>16     | YEAR<br>84 | 2b. HOUR<br>6:30A <sub>M</sub> |
| 3. SEX<br>FEMALE   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH<br>11-7-1915  | YEAR<br>1915  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 68 YRS  | 7. IF UNDER 1 YEAR<br>MONTHS<br>DAYS   |   | 8. IF UNDER 72 HRS<br>HOURS<br>MIN.  |   |               |            |                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                  |   |  |   |  |   |               |            |                                |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N.CHARLES ST. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Personnel Asst. G.M. |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |   |               |            |                                |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1005B Pleasant Oaks Rd. 21234                      |   |  |   |               |            |                                |
| 14. FATHER'S NAME<br>FIRST<br>George   |  | MIDDLE<br>Harry   | LAST<br>Eser, Sr.   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Alice  |  |   |  | MIDDLE<br>M.  | LAST<br>Green |            |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-10-9887  |   | 17. INFORMANT<br>G. Harry Eser, Jr. Same as 13e   |  |   |  | ADDRESS   |               |            |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) METASTATIC BREAST CA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 YR. |               |            |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |               |            |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |   |               |            |                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |               |            |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/01 19 84, to 5/16 19 84, that (I) (we) last saw the deceased alive on 5/16 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  | 22c. DATE SIGNED<br>5/16/84                           |               |            |                                |
| 22a. SIGNATURE<br>Kenneth D. Byerly, M.D.  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22e. ADDRESS<br>GBMC 6701 N.CHARLES ST.   |  |   |  |   |               |            |                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5-19-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md. |  |   |               |            |                                |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.  |  |   |   | 25. DATE REC'D. BY REGISTRAR<br>MAY 18 1984   |  |   |  |   |               |            |                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

Anthony M.

REG. NO.

|   |  |   |  |  |  |  |  |  |   |   |  |
|---|--|---|--|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony M. Esposito</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>4</b> YEAR <b>1984</b>      |  |  | 2b. HOUR<br><b>9:50 P.M.</b>   |  |  |   |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>10</b> YEAR <b>19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |   | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                              |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beth steel/Hangermill</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>                     |   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET ADDRESS / ZIP CODE<br><b>230 S. HAVEN ST 21224</b>   |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Antonio</b> MIDDLE <b>Esposito</b> LAST <b>Esposito</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Saveria</b> MIDDLE <b>Martini</b> LAST <b>Martini</b>   |  |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-6960</b>   |  | 17. INFORMANT<br><b>Michael Esposito</b>   |  | ADDRESS <b>1847 Merritt 21232</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic bronchogenic carcinoma Stage II</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe COPD - ASCVD &amp; mitral insufficiency - Atrial flutter-fibrillation</b> |  |   |  |  |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/21/84</b> , 19 <b>84</b> , to <b>MAY 4</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/4/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.            |  |   |  |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Guillermo Vanegas MD</b>   |  |   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Guillermo Vanegas MD</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>7600 Osler Dr. 205 Towson Md 21204</b>  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   | 23b. DATE<br><b>5-8-84</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oakwood Cem.</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph N. Zannino Jr.</b> ADDRESS <b>263 S. Cookline St. Baltimore Md</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Wardson-Hendall</b>             |   |  |

1953

2/1/53

(1)

Referred to the  
National Commission on the  
Structure of the  
Government

2000 (1953) - 1953 (1953) - 1953 (1953)

1953 (1953) - 1953 (1953) - 1953 (1953)

1953 (1953) - 1953 (1953) - 1953 (1953)

1953 (1953) - 1953 (1953) - 1953 (1953)

1953 (1953) - 1953 (1953) - 1953 (1953)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIRGINIA May Everett</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 10, 1984</b>  |  |  |  |
| 2b. HOUR<br><b>9:00P<sub>M</sub></b>   |  |  |  |  |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 11, 1939</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>44</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N CHARLES ST</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Data Entry</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Smelkinson Brothers</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Crum, Sr.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther A. Harris</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215/40/4304</b>   |  | 17. INFORMANT (Husband) ADDRESS<br><b>Mr. James L. Everett Same as #13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539 IMMEDIATE CAUSE (a) BOWEL OBSTRUCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC COLON CA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____                   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> , 19 <b>84</b> , to <b>5/10</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5/10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>P. Siemer MD</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>5/10/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR P. SIEMER</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 14, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel-Air Mem. Gardens</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bel-Air Harford Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Singleton Funeral Home</b> ADDRESS <b>Glen Burnie, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>  |  |  |  |



BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR   |  |                    |  |   |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |  |  |  |  |  |  | REG. NO.               |  |                         |  |
|---|--|--------------------|--|---|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|------------------------|--|-------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Robert Faulcon</b>   |  |                    |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <b>5/5/84</b>                                  |  |   |  |  |  |  |  |  |  | 2b. HOUR <b>2:18</b> M |  |                         |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>BLK</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 2 26</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.                    |  | IF UNDER 1 YR.<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD <b>5/5/84</b>                        |  |  |  |  |  |  |  |                        |  | 2d. HOUR <b>3:45</b> PM |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO. MD.</b>   |  |                    |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. County</b> MD. |  |  |  |  |  |  |  |                        |  |                         |  |
| 10. CITY OR TOWN OF DEATH <b>TURNERS Station</b>  |  |                    |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>608 NEW PITTSBURGH AV.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMPLOYED</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>                |  |  |  |  |  |  |  |                        |  |                         |  |
| 13a. STATE <b>MD</b>  |  |                    |  | 13b. COUNTY <b>BALTO.</b>   |  | 13c. CITY OR TOWN <b>TURNERS STATION</b>                          |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>846 PEACH ORCHARD LANE</b>                                  |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>ROBERT Faulcon sr.</b>  |  |                    |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>SUSIE HARRIS</b> |  |  |  |  |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |  |                    |  | 16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>   |  | 17. INFORMANT <b>Dorothy Faulcon</b>                              |  |  |  | ADDRESS <b>RD. BK 4029 846 Peach Orchard Ln</b>                                    |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Heart Failure</b><br><b>2500</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Diabetes Mellitus</b><br>(c) _____   |  |                    |  |   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |  |  |  |                        |  |                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                    |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 19a. DATE OF OPERATION  |  |                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                        |  |                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                    |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| ACTUAL SIGNATURE <b>Theoc Patterson</b>   |  |                    |  | TITLE (SPECIFY) _____   |  |   |  | DATE SIGNED <b>5/5/84</b>  |  |  |  | MEDICAL EXAMINER  |  |  |  |  |  |  |  |                        |  |                         |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>THEOC PATTERSON</b>  |  |                    |  | ADDRESS <b>3427 Dundalk Ave</b>   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>  |  |                    |  | 23b. DATE <b>5/7/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW</b>                |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY <b>BALTO. 21222 MD</b>                        |  |   |  |  |  |  |  |  |  |                        |  |                         |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>James A. Morton</b>   |  |                    |  | ADDRESS <b>714 1701 LAURENS ST.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 7 1984</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Jane [Signature]</b>            |  |  |  |  |  |  |  |                        |  |                         |  |

MEDICAL CERTIFICATION

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept in 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

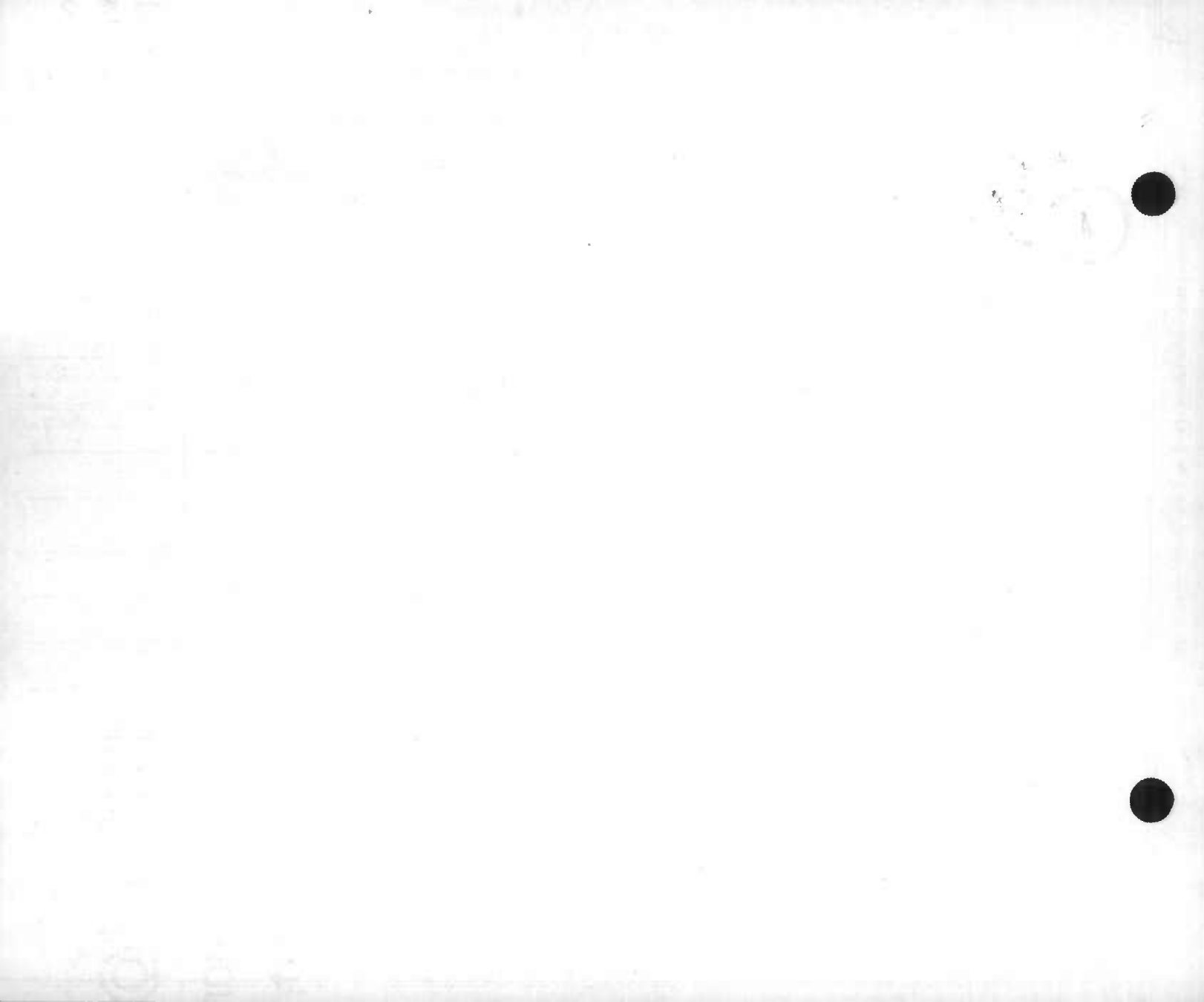
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                                  |   |   |  |  |  |
|---|--|--|--|---|----------------------------------|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Francis Fernanders</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-30-84</b>                |   |                                  | 2b. HOUR<br><b>1 AM</b>   |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-19-22</b>  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62 YRS.</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>62 YRS.</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHING. D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BLA TAWES Nursing Hm</b> |  |   |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Furniture Mover</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Virginia</b>   |  |  | 13b. COUNTY<br><b>Arlington</b>                                      |   | 13c. CITY OR TOWN<br><b>none</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EARL W. Fernanders</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Janifer</b> |   |                                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>Yes WWII-Korean</b>   |   |  | 16b. SOCIAL SECURITY NO.<br><b>229-16-3484</b> |  |
| 17. INFORMANT<br><b>Margaret Fernanders</b>   |  |  | ADDRESS<br><b>2102 So. Shirlington Road<br/>Arlington, VA 22206</b>  |   |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio - Pulmonary Arrest.</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>C.V.A.</b><br>(c) <b>A.S.C.V.D.</b> |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |                                  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-23-19-83</b> to <b>5-30-19-84</b> , that (I) (we) last saw the deceased alive on <b>5-30-19-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>H. Sevados</b>   |  |  |  | DEGREE<br><b>MD</b>   |                                  |   |   | 22c. DATE SIGNED<br><b>5/30/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. D. SEVADOSS</b>  |  |  |  | 22e. ADDRESS<br><b>Tawes / BB - 5GHC.</b>   |                                  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6/2/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>pleasant Valley mem pk</b>   |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annandale, Virginia</b>  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chinn Funeral Service</b>  |  |  |  | 25a. ADDRESS<br><b>2605 So. Shirlington Rd.<br/>Arlington, Va.</b>  |                                  | 25b. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1984</b>  |   | 25c. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                                       |  |   |  |   |  |
|---|--|--|---|---|---------------------------------------|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Minnie - FISCHER</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 16, 1984</b> |   |                                       | 2b. HOUR<br><b>4:35P M</b>   |   |  |   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 17 1895</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                    |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD.</b> |  |  | 13b. COUNTY<br><b>BALTO.</b>                            |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1 EASTERN BLVD. BALTIMORE N.H. 21221</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |                                       |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>NO</b>                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-54-3399</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>DORIS MARKOWSKI (DGHTR) 505 N. BOULDIN ST. 21205</b>   |                                       |  |   |  |   |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>5829</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Renal Insufficiency</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 11</b> , 19 <b>84</b> , to <b>May 16</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive <b>May 16</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>C. Joseph M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/16/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. Joseph M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |   |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/21/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NAT'L</b> |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>BALTIMORE MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCHIMUENK FUNERAL HOME, INC.</b><br>ADDRESS<br><b>3331 Brehms Lane, Balto. Md. 21213</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 17 1984</b>          |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner will be notified at once.

BP

(A)



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

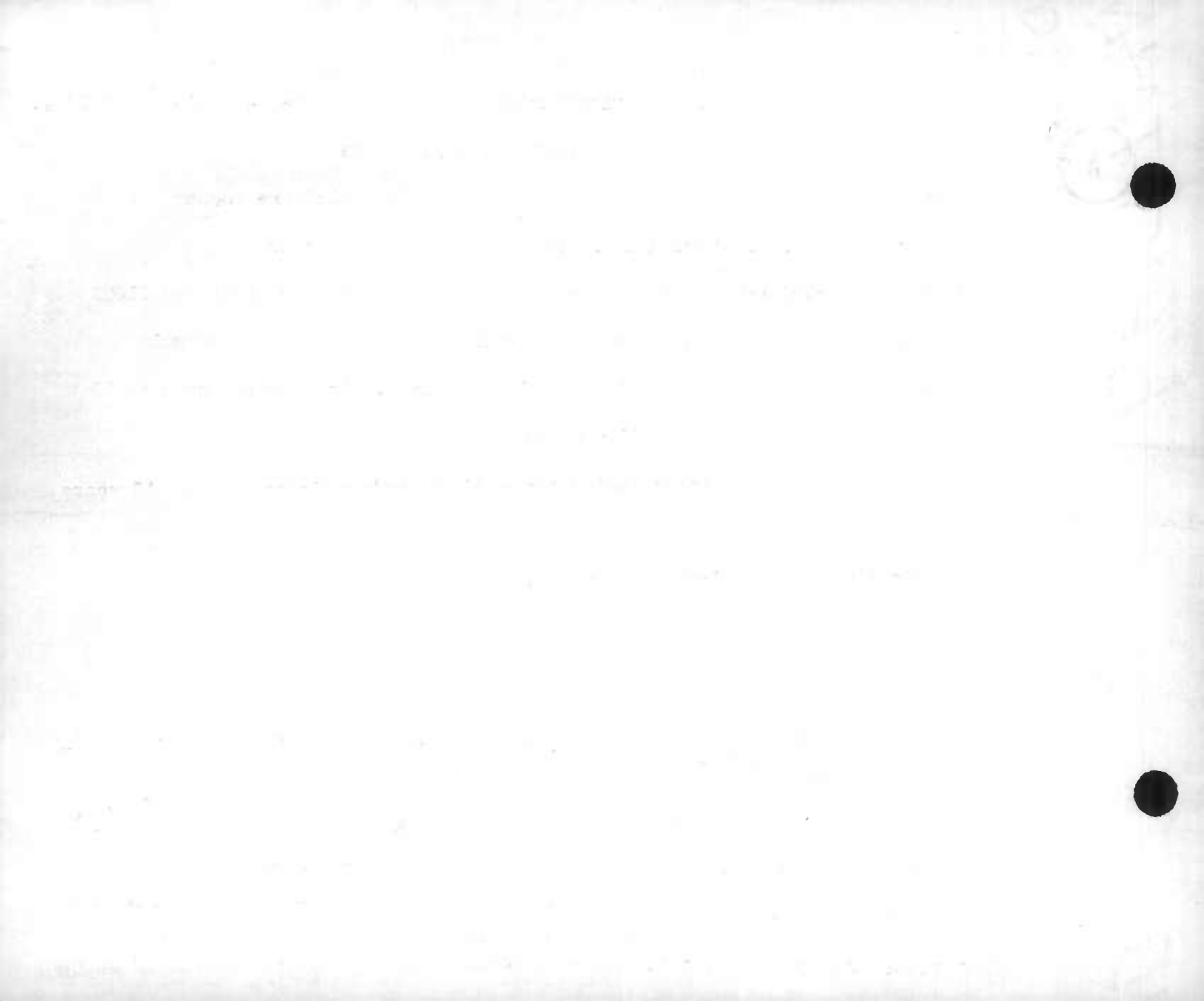
|   |  |  |  |   |   |  |   |  |  |   |  |
|---|--|--|--|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thekla E. FitzPatrick</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 4, 1984</b>              |   | 2b. HOUR<br><b>5:50 P.M.</b>                          |  |   |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 25, 1891</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Ruxton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Ruxton Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Lutherville</b>               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>33 Thornhill Road 21093</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Heinrich Ebentheuer</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Waegele</b>   |   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-32-7630</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Miss Thekla M. FitzPatrick same as 13 e</b>  |   |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senile brain syndrome 15 years.</b> |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 years</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)  |  |  |  |   |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 2</b> , 19 <b>66</b> , to <b>May 4</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>April 20</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Donald O. Wood</b>   |  |  |  |   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |   | MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                              |  | 22c. DATE SIGNED<br><b>5/7/84</b>                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald O. Wood, M.D.</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>2 Greenmeadow Drive</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>5-7-1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b> |  |   | 23d. LOCATION<br><b>Baltimore</b> COUNTY <b>Maryland</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |  |  |   |   | ADDRESS<br><b>1050 York Road</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, tell the medical examiner, or the medical director.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 4 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Joanne Fleckenstein</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5/21/84</i> |   |  | 2b. HOUR<br>MIN.<br><i>4:00 A.M.</i>  |  |
| 3. SEX<br><i>FEMALE</i>   |  | 4. RACE<br><i>WHITE</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 25 1897</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>87</i>                                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE COUNTY</i> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><i>TOWSON</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SAINT-JOSEPH HOSPITAL</i> |   |   |  | 12a. USUAL OCCUPATION<br>(LAST WORK FOR MOST OF WORKING LIFE)<br><i>TEACHER</i>                 |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. CITY OR TOWN<br><i>BALT.</i>  |   | 13c. CITY OR TOWN<br><i>TOWSON</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>CHARLES FLECKENSTEIN</i>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>MARY SMITH</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i> |  | 16b. SOCIAL SECURITY NO.<br><i>577-68-3532</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>CONVENT RECORDS</i>  |  |   |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*septicemia*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*2 days**2041*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Chronic lymphocytic leukemia and**3 years*

DUE TO, OR AS A CONSEQUENCE OF

(c) *breast carcinoma**3 years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

*Large bowel obstruction and congestive heart failure*

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
*P.M. 19*

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(CHECK)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

GENERAL DIRECTOR

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible handwritten text and markings covering the majority of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Howard F. FOSNAUGHT</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 10, 1984</b>             |   |  | 2b. HOUR<br><b>11:25p<sub>M</sub></b>  |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8- 16- 1929</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance-Harrison Steel</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7700 Wynbrook Rd. 21224</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard F. Fosnaught</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy N. Durst</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-26-2880</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Helen A. Fosnaught 136 S. Highland Ave. 21224</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Lung Cancer</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 5</b> , 19 <b>84</b> , to <b>May 10</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 10</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Donald Richter MD</b>  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5-10-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald Richter, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>5-14-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Balto., Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lasech FH 7401 Belair Rd.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><b>MAY 15 1984 Julia Swanson-Richter</b>   |  |  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |   |  |                  |  |
|--|--|--|--|---|--|---|---|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>KATHERINE - FRAMPTON  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 13, 84                      |   |  | 2b. HOUR<br>2:22 P M  |   |  |                  |  |
| 3. SEX<br>F  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7-11-1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CO. MD.                        |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>BALTO. CO. GEN. HOSP. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                  |  |
| 13a. STATE<br>MD.  |  |  | 13b. COUNTY<br>BALTO.  |   | 13c. CITY OR TOWN<br>DUNDALK   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN HACK  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CARRIE NEIMHSTER      |   |  | 13e. STREET ADDRESS<br>227 PARKWOOD RD. 2222                                  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>213-16-3425                                |   | 17. INFORMANT<br>HARRIET RUCZYNSKI   |   |   |  | ADDRESS<br>SAME. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>chronic renal failure</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diabetes mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |  |   |  |   |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |   |  |                  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1984</u> , to <u>May 13, 1984</u> , that (I) (we) lost<br>saw the deceased alive on <u>May 13, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |                  |  |
| 22b. SIGNATURE<br>Shanem Pounmotabed, M.D.   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br>5-13-84  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GHASSEM POUNMOTABED   |  |  |  |   | 22e. ADDRESS<br>Balto. Co. General Hospital  |   |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  |  | 23b. DATE<br>5-17-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. CO. MD.                                    |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS J. SKARDA   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 16 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| No. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|-----|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|
| 1   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |
| 2   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

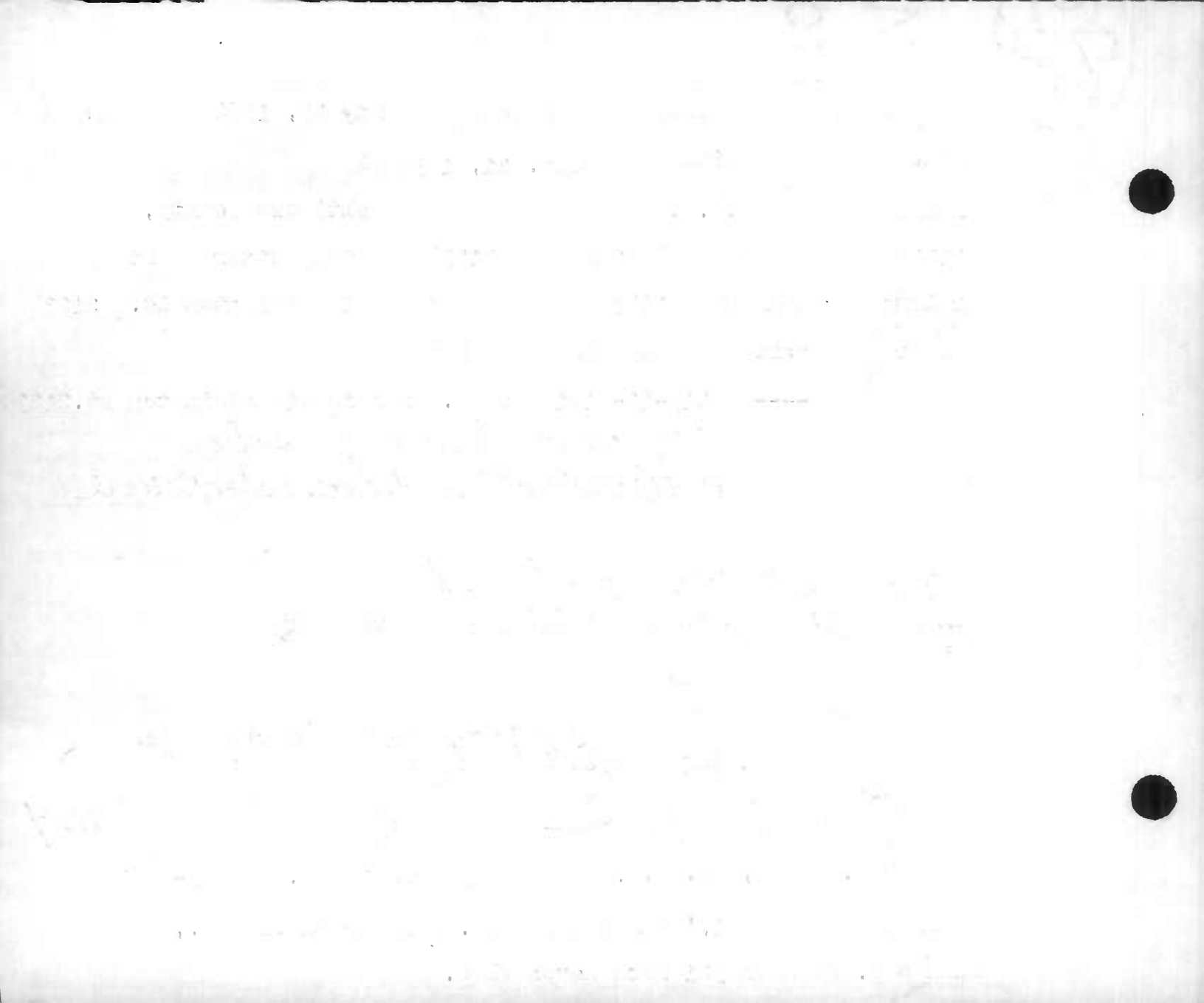
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE HENRY FRANCIS</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 29, 1984</b>  |   | 2b. HOUR<br><b>8:50A.M.</b>   |
| 1 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 21, 1899</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>21234</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8710 Eddington Road 21234</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Metal Cutter</b>                         |   |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>Baltimore</b>                             | 13c. CITY OR TOWN<br><b>21234</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Harry Francis</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215-12-0191</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mary E. Francis 8710 Eddington Rd. 21234</b>                                     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4292 Myocardial decompensation</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Transient Cerebrovascular occlusion</b>   |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>Apr 26 84</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Strangulated Femoral Hernia</b>  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 20c. HOW INJURY OCCURRED<br>ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2                                 |   |
| 21a. INJURY OCCURRED<br>WHERE <input type="checkbox"/> HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 78</b> to <b>May 84</b> that (I) (we) last saw the deceased alive on <b>4/30/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.                                    |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Frank R. Kasik, Jr.</b>   |   | DEGREE:<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   | 22c. DATE SIGNED<br><b>5/29/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frank R. Kasik, Jr. M.D.</b>   |   | 22e. ADDRESS<br><b>9005 Harford Rd. 665-8692</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>May 31, '84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., MD</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |   | ADDRESS<br><b>8521 Loch Raven Blvd.</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>  |   |
|  |   |   |   | 26. REGISTRAR'S SIGNATURE<br><b>Davidson-Randell</b>  |   |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

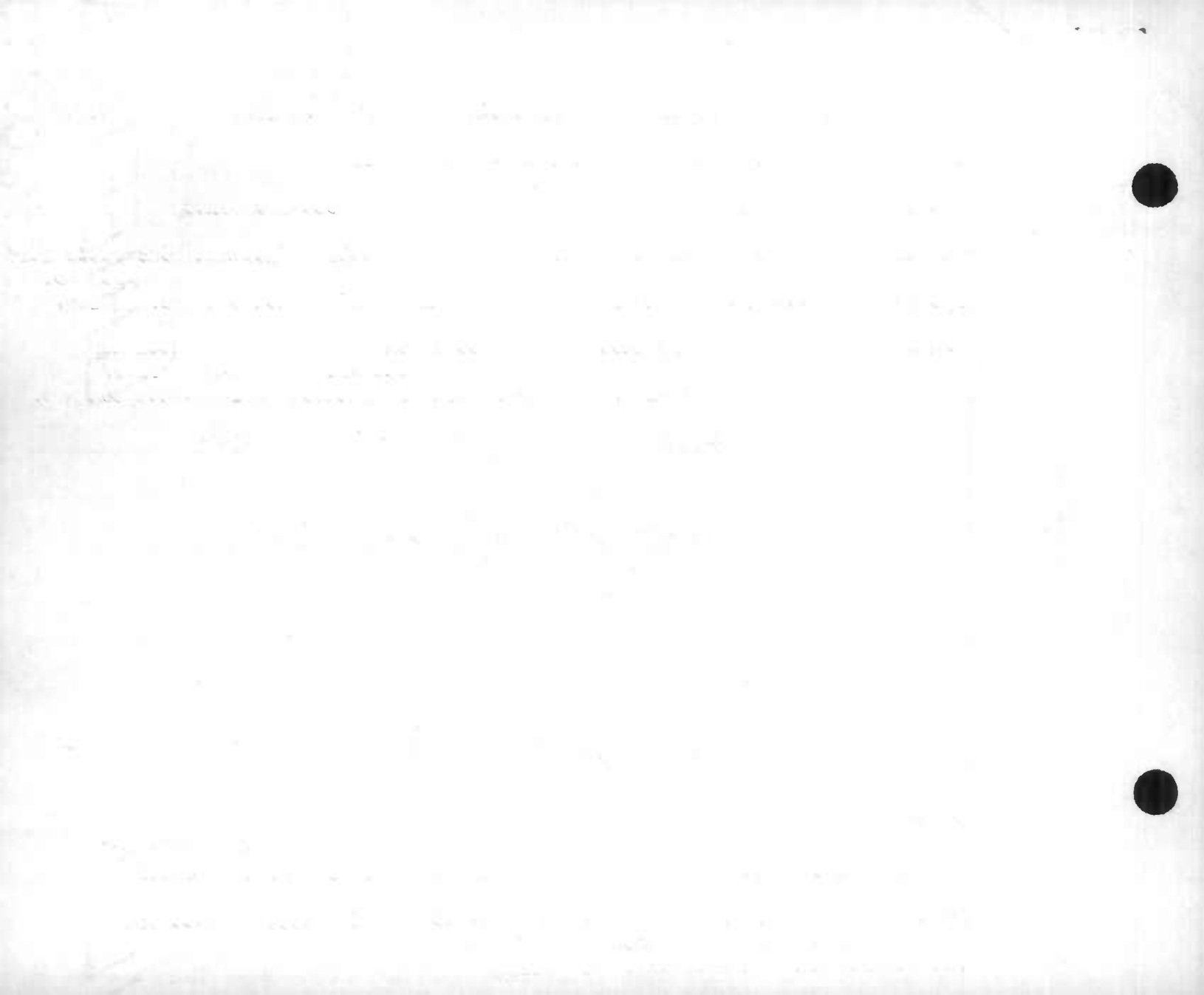
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>John Howard Franklin</i>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>May 27, 1984</i>  |  |
| 3. SEX<br><i>Male</i>  |  | 2b. HOUR<br><i>2:00P M</i>   |  |
| 4. RACE<br><i>Caucasian</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>August 11, 1915</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rockdale</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>3619 Washington Ave.</i> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired Salesman</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Pikesville Tire &amp; Supply Co.</i>   |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |  |
| 13c. CITY OR TOWN<br><i>Rockdale</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><i>3619 Washington Ave. 21207</i>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Wade J Franklin</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Elizabeth Gallagher</i>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>212-10-7564</i>   |  |
| 17. INFORMANT<br><i>Baltimore</i> ADDRESS<br><i>MD 21207</i>   |  | Mrs. Fern C. Franklin 3619 Washington Ave.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Intestate carcinoma recto sigmoid</i><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>Malnutrition</i><br>(c) <i>Multiple myeloma</i>                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 23</i> 19 <i>84</i> to <i>May 27</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>May 23</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><i>Samuel P. Scalia MD</i>   |  | 22c. DATE SIGNED<br><i>5-28-84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Samuel Scalia</i>  |  | 22e. ADDRESS<br><i>2111 Cedar Circle Drive 21228</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>5/30/84</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge Cemetery</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Pikesville Baltimore MD</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors, Inc.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 31 1984</i>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Rendell</i>  |  |  |  |

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Maude Irene FRANKLIN   |  | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 28 84  |  | 7b. HOUR<br>8:35 PM  |  |
| 3. SEX<br>F   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 10 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>0 18   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Carroll   |  | 13c. CITY OR TOWN<br>Mt. Airy   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>4368 Ridge Road (12771)   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Coale Sappington  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosella Stitely   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>217-36-4593B  |  | 17. INFORMANT<br>Merton L. Franklin, Same As #13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4368 IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CEREBROVASCULAR ACCIDENT</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>HYPERTENSION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br><u>ASCVD</u>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Hafeez A. Syed</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>5/28/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAFAEE2 SYED   |  | 22e. ADDRESS<br>BALTIMORE COUNTY GEN HOSP.   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>6-1-1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Taylorsville  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Carroll Md.                                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles W. Burrier, Jr., Sykesville, Md.  |  | ADDRESS  |  | JUN 01 1984   |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED  
JAN 10 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text block containing several lines of typed information, possibly a memorandum or report header.]

[Large block of illegible, mirrored text, likely bleed-through from the reverse side of the page.]

100-100000-1000  
[Illegible text at the bottom of the page, possibly a file number or administrative note.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

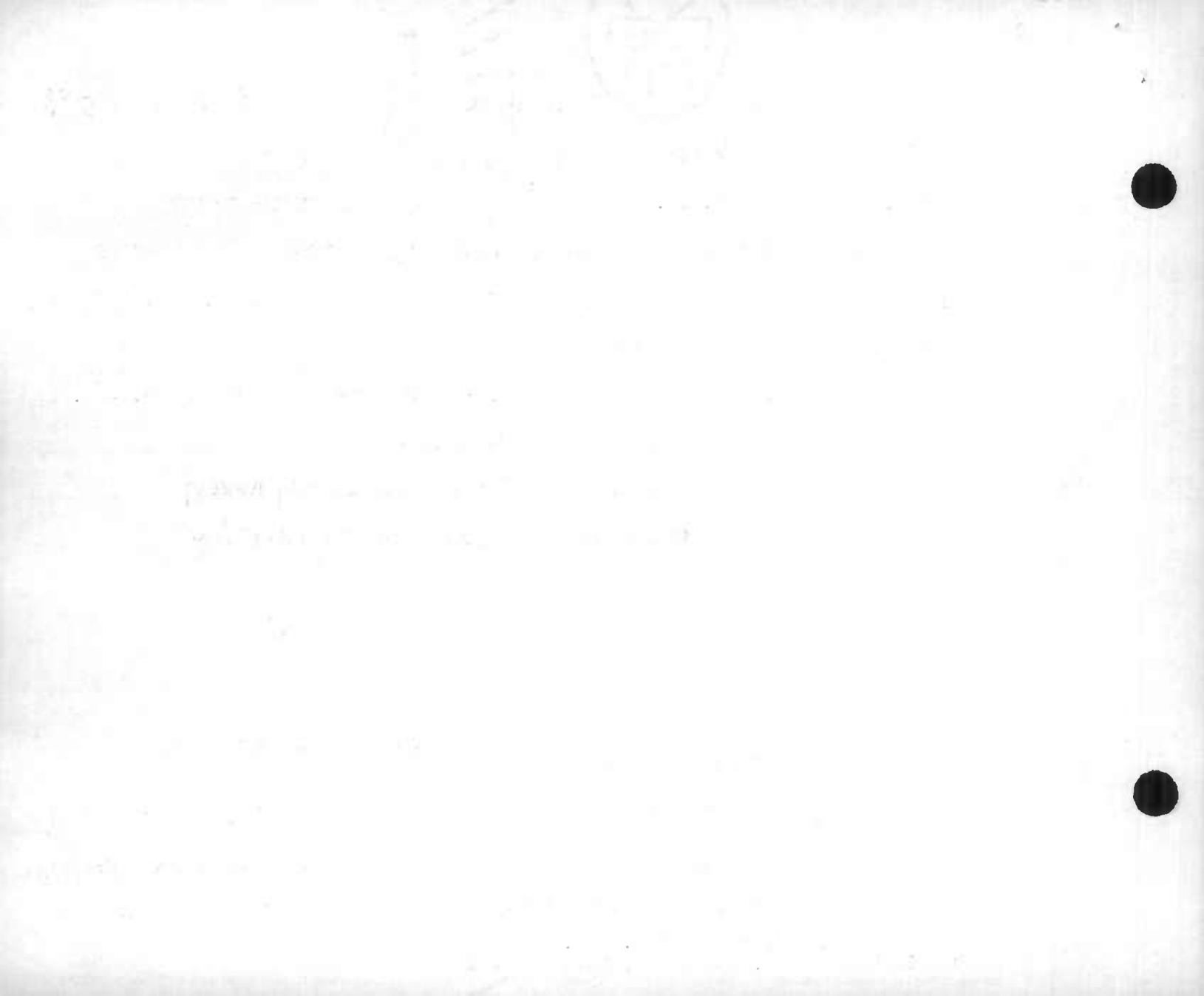
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   | REG. NO.                                  |  |
|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MORTON MIDDLE LAST FRIEDMAN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 27 84  |   | 2b. HOUR<br>5 55 P.M.                     |  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 3 16  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GENERAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DRIVER                      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>CABS |  |
| 13a. STATE<br>MARYLAND   | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>6960 MARSUE DR., APT. 1D (21215)  |   |  |
| 14. FATHER'S NAME<br>FIRST JOSEPH MIDDLE LAST FRIEDMAN   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST LEAH MIDDLE LAST COHEN  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>WWII-ARMY 213-09-4227   |   | 17. INFORMANT<br>ADDRESS<br>MRS. RUTH FRIEDMAN 6960 MARSUE DR., APT. 1D (21215)   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST-</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>STATUS POST CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PROBABLE MYOCARDIAL INFARCTION</u>   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-27-1984</u> to <u>5-27-1984</u> , that (I) (we) lost saw the deceased alive on <u>5-27-1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |
| 22b. SIGNATURE<br><i>DePestre</i>  |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>5-27-84  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. DEPESTRE   |  | 22e. ADDRESS<br>BALTIMORE COUNTY GENERAL HOSPITAL   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>5/29/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BNAI ISRAEL CEM   |   | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND   |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 31 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Kelia Davidson-Randall</i>  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked "other," the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |                                 |  |  |
|---|--|---|--|---|--|---|---------------------------------|--|--|
| REG. NO.  |  |   |  |   |  |   |                                 |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James H Fuchs  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-24-84  |  |   | 2b. HOUR<br>8:45pm <sub>M</sub> |  |  |
| 3 SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 13, 1928  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Preston, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                   |                                 |  |  |
| 11. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer; Irrig. contractor |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Caroline 13c. CITY OR TOWN   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13. STREET ADDRESS / ZIP CODE<br>Rt. 1 Box 46 Preston Md. 21655                               |                                 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Conrad Fuchs  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline Kleinwachter  |  |   |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>216-18-8143   |  | 17. INFORMANT ADDRESS<br>21655 James R. Fuchs, Rt. 1, Box 46, Preston, Md.                    |                                 |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ATELECTASIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) HYDROTHORAX   |  |   |  |   |  |   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>CARCINOMATOSIS, PRIMARY IN LUNG   |  |   |  |   |  |   |                                 |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |                                 |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                 |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5-23, 19 84, to 5-24, 19 84, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5-24, 19 84, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |   |                                 |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |                                 | 22c. DATE SIGNED<br>5-26-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>REYNALDO ORJUELA-GOMEZ M.D.  |  |   |  | 22e. ADDRESS<br>7620 York Road towson Md 21204  |  |   |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>May 27, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Junior Order Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Preston, Caroline, Maryland                     |                                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Frampton-Hawkins Funeral Home, 216 N. Main St.  |  | ADDRESS<br>Federalburg  |  | DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE<br>MAY 31 1984 Julia Davidson-Randall  |  |   |                                 |  |  |

444

2000 2001

2410-61-815

James H. Pugh, Jr., Box 40, Preston, Mo.

In 1998,

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                               |
|---|--|---|---|---|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nazario E Gabriele</b>                     |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>5-3-84</b>  |   | 2b. HOUR <b>2:19pm</b>        |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 28, 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                     | # UNDER 1 YEAR<br>MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> , MD.                 |                               |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE, GIVE STREET ADDRESS)<br><b>St Joseph hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b> |                               |
| 13a. STATE<br><b>Pennsylvania</b>   |  | 13b. COUNTY<br><b>Hazleton</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>532 Peace Street 18201</b>                       |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Biaggio Gabriele</b>                 |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Camella Fuccilo</b>                         |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>171-01-7013</b>  |   | 17. INFORMANT ADDRESS<br><b>Moran Funeral Home Hazleton, Pennsylvania</b>             |                               |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **ACUTE RENAL INSUFFICIENCY**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(b) **ACUTE TUBULAR NECROSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **HYPOTENSION**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**CARDIAC FAILURE AND DISSEMINATED INTRAVASCULAR COAGULATION - NEPHROSCLEROSIS**

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>4-19-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CORONARY ARTERY INSUFFICIENCY</b> |  | 19c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (SEE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (this hospital) attended the deceased from <b>4-13</b> , 19 <b>84</b> , to <b>5-3</b> , 19 <b>84</b> , that (he) (we) lost<br>saw the deceased alive on <b>5-3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (we) (we) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br>  |  | DEGREE   |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>REYNALDO ORJUELA-GOMEZ, M.D.</b>  |  | 22e. ADDRESS<br><b>7620 York Road Towson Md 21204</b>                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |

|   |                                 |   |  |
|---|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                           | 23b. DATE<br><b>May 7, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Drums, Pennsylvania</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> |                                 | 25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1984</b>               |  |
| 25b. REGISTRAR'S SIGNATURE<br>  |                                 |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

July 20, 1975

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Средствами

4-22-68, 08-07-68, 09-01-68, 09-01-68, 09-01-68

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |  |  |   |  | REG. NO. 12350  |  |   |  |
|--|--|------------------|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>LEONARD MARTIN GAFF   |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>5 8 1984                               |  | 2b. HOUR<br>M                                 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cauc. |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 20 1954   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>30 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5 8 1984                              |  | 2d. HOUR<br>10a M                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Parkville   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>9616 Mason Ave. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Surveyor   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Surveyor |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>9616 Mason Ave Balto. MD. 21234                              |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Joseph Gaff   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Josephine Durlin                                |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-64-7695  |  | 17. INFORMANT<br>ADDRESS<br>John Joseph Gaff 1610 Del. Rd. 21160                                       |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9503 IMMEDIATE CAUSE (a). Acute amitriptyline intoxication<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b).<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                  |  |   |  |  |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                  |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 5/8 1984  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject ingested drug |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>9616 Mason Ave. Parkville Balto., Md. Co.         |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon   |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>5-8-84   |  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |                  |  | 23b. DATE<br>5-9-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph N. Zannino  |  |                  |  | ADDRESS<br>2635 Conkling  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 11 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |  |

RECEIVED  
FEBRUARY 1964

RECEIVED  
FEBRUARY 1964

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WIND



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                                    |   |  |  |  |  |  |
|---|------------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Joe JOSEPH Gajdosik JR  |                                    |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 17, 1984   |  |  | 2b. HOUR<br>11:24am  |  |
| 3. SEX<br>M   | 4. RACE<br>W                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/5/11  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MINS                 |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA.   | 9. CITIZEN OF WHAT COUNTRY?<br>USA |   | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD |  |  |
| 12. CITY OR TOWN OF DEATH<br>ROSSVILLE  |                                    | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DISTILLERY  |  | 15. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE MD 16b. COUNTY BALTO 16c. CITY OR TOWN MIDDLE RIVER   |                                    | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 18. STREET ADDRESS / ZIP CODE<br>1200 BREEZE DR 21220                          |  |  |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH GAJDOSIK   |                                    |   | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOUISE MACK   |  |  |  |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNK  |                                    | 22. SOCIAL SECURITY NO.<br>307-03-7963  |  | 23. INFORMANT<br>ADDRESS 7405 EUNBOWER<br>JOSEPH GAJDOSIK HIL                  |  |  |  |
| 24. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) Myocardial infarction Immediate<br>(b) Due to, or as a consequence of, Atherosclerotic coronary artery disease Type<br>(c) Due to, or as a consequence of, Hypertension, Diabetes |                                    |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |                                    |   |  |  |  |  |  |
| 25a. DATE OF OPERATION  |                                    | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 26a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, HISTORY MEDICAL EXAMINER)   |                                    | 27b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 28a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                    | 28b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 28c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 29. I certify that (I) (the hospital) attended the deceased from Dec 8 19 60 to May 17 19 84 that (I) (we) last saw the deceased alive on Apr 23 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.           |                                    |   |  |  |  |  |  |
| 30a. SIGNATURE<br>LOUIS SEMENO HIL  |                                    | 30b. PHYSICIAN'S NAME (PRINT OR PRINT)<br>LOUIS SEMENO HIL  |  | 30c. ADDRESS<br>2108 OREGON RD BALTO MD 21220                                  |  | 30d. DATE SIGNED<br>5/18/84  |  |
| 31a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION   |                                    | 31b. DATE<br>5/18/84  |  | 31c. NAME OF CEMETERY OR CREMATORY<br>SECURITY PROCESS                         |  | 31d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD   |  |
| 32. FUNERAL DIRECTOR<br>NAME J.G. CONNELLY ADDRESS 300 MACE   |                                    |   |  | 33. DATE REC'D. BY REGISTRAR<br>MAY 22 1984                                    |  | 34. REGISTRAR'S SIGNATURE<br>Jia Davidson-Randell  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>STEPHEN J. JOSEPH GALLA, SR.<br>STEPHEN J. GALLA   |  |   |  | 5/23/84   |  |   |  | 10:40 P.M.  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 1, 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Connecticut   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>STELLA MARIS Hospice |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ford Motor Co.                       |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>Dulaney Valley Rd. 21204                |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Stephen J. Galla  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sofia Anna Liscinsky  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW I  |  | 17. INFORMANT ADDRESS<br>San Francisco, Calif. 94131  |  | 17. INFORMANT ADDRESS<br>Lawrence Galla, 160 Monterey Blvd., Apt. 3                             |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5860 IMMEDIATE CAUSE (a) Renal Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <input checked="" type="checkbox"/><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <input type="checkbox"/>   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1/83 to 5/23/84, that (I) (we) lost saw the deceased alive on 5/23/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>K. Faulkner MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>5/23/84   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Kendall Faulkner  |  |   |  | 22e. ADDRESS<br>Stella Maris Hospice - Towson Md.   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>5-29-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Michael's   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Stratford Conn.                |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.  |  |   |  | ADDRESS<br>1050 York Rd.<br>Towson, Md. 21204   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                      |  |  |  |

Black Townson Funeral Home, Inc. 21204  
 1030 York Rd.  
 St. Michael's  
 2-29-64

Sturford Conn.

Yes  
 NW 1

300-00-3200

San Francisco, Calif. 94111  
 100 Monterey Blvd., Apt. 3

Stephen

1.

Calif

Boyle

Anna

Lisiansky

Maryland

Baltimore

Towson

x

Delaney Valley Rd. 21204

Engineer

Ford Motor Co.

Connecticut

U.S.A.

x

COUNTY

Male

White

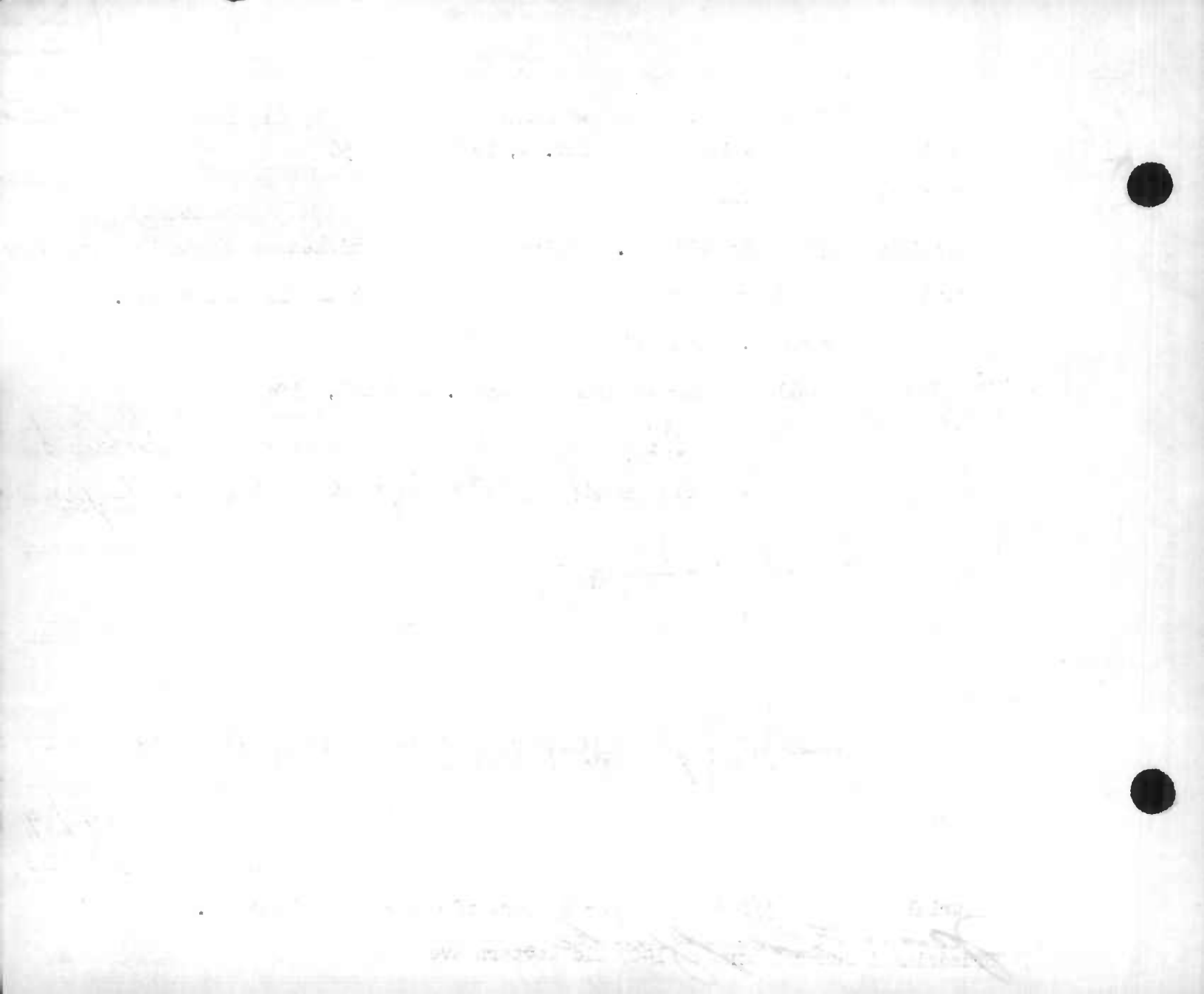
July 1, 1937

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |   | MONTH DAY YEAR  |  |
| George C. GAPINSKI   |  | May 11, 1984   |   | 2:18P   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR   |  |
| Male   | White  | Nov. 4, 1927   | 56  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |
| Illinois   | USA  |  | Baltimore County MD   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |
| Rossville 21237  | Franklin Sq. Hospital  | Maintenance Mechanic   | Industry  |   |  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE               |
| Maryland   | Baltimore  | Essex 21221  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1722 Old Eastern Ave. 21281   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |   |   |  |
| Frank C. Capinski  |  | Emma   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)  |   | 17. INFORMANT ADDRESS   |  |
| Yes  |  | WWII 319 20 2351   |   | Mary E. Capinski, Wife  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4100 IMMEDIATE CAUSE (a) Myocardial infarction   |  |  |   |   | Immediate                                    |
| DUE TO, OR AS A CONSEQUENCE OF (b) Coronary vas. dis.  |  |  |   |   | 2 yrs  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension  |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?   |  |
|  |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |
|  |  | P.M. 19  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |
|  |  |  |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from May 9, 1984, to May 11, 1984, that (I) (we) last saw the deceased alive on May 9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED  |  |
| LOUIS SEMENOFF   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 5/14/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |   |  |
|  |  | 2105 OREMS RD BAY MD 21220   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | 5/14/84  |   | Sacred Heart of Jesus   |  |
| 23d. LOCATION  |  | 23e. DATE REC'D. BY REGISTRAR  |   | 23f. REGISTRAR'S SIGNATURE  |  |
| Baltimore Md. COUNTY STATE   |  | MAY 16 1984  |   | Julia Davidson-Randall  |  |
| 74. FUNERAL DIRECTOR   |  | 75. NAME   |   | 76. ADDRESS   |  |
| Bruzdzinski Funeral Home PA  |  | 1407 Old Eastern Ave   |   |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |
|---|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HELEN KNORR GAREIS</b>      |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 30, 84</b> |   | 2b. HOUR<br><b>1126 P.M.</b>   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9-11-06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Presbyterian Home of Maryland</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |   |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frederick McMannus Knorr</b>                  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emelie Elizabeth Weisner</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-5265</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. G.A. Turner 426 Deacon Brook Cir. 21136</b>  |  |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY Arrest**  
4100  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Acute coronary occl.**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **Atherosclerotic Cardiovascular Dis.**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

M.I.

M.I.

YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Hypertensive Cardiovascular Disease**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-27, 19 29</b> to <b>May 30, 19 84</b> , that (I) (we) last saw the deceased alive on <b>May 23, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Dr. S. J. Venable</b> DEGREE <b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-1-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. S. J. Venable</b>  |  |  |  | 22e. ADDRESS<br><b>7215 York Road 21212</b>  |  |  |  |

|   |  |                            |  |  |  |   |  |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                  |  | 23b. DATE<br><b>6-2-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b> |  |                            |  | 25a. REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUN 5 1984</b> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-BB be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

May 20 1954

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Henry Harold Garvey  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 11 84                         |   |   | 2b. HOUR<br>7:40am   |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 4 04  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Martin's Home for the Aged |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Adjuster   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   | 13b. CITY OR TOWN<br>Montgomery  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br>1602 Marshall Ave. 20850                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leo Garvey  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Maisel           |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |   | 16b. SOCIAL SECURITY NO.<br>212-07-0512                                |   | 17. INFORMANT<br>Sr. Mary Augustine 601 Maiden Choice Lan                                       |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u><br><u>2396</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA TONGUE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo</u><br><u>1 year</u> |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>ATHEROSCLEROTIC HEART DISEASE</u>   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <u>5-10-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Sambandam Baskaran</u>   |  |   |  |   |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>5-11-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sambandam Baskaran, M.D.   |  |   |  |   |   | 22e. ADDRESS<br>3455 Wilkens Avenue, 21229                                     |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>05-14-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1984                                   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Richard Davidson</u>  |  |

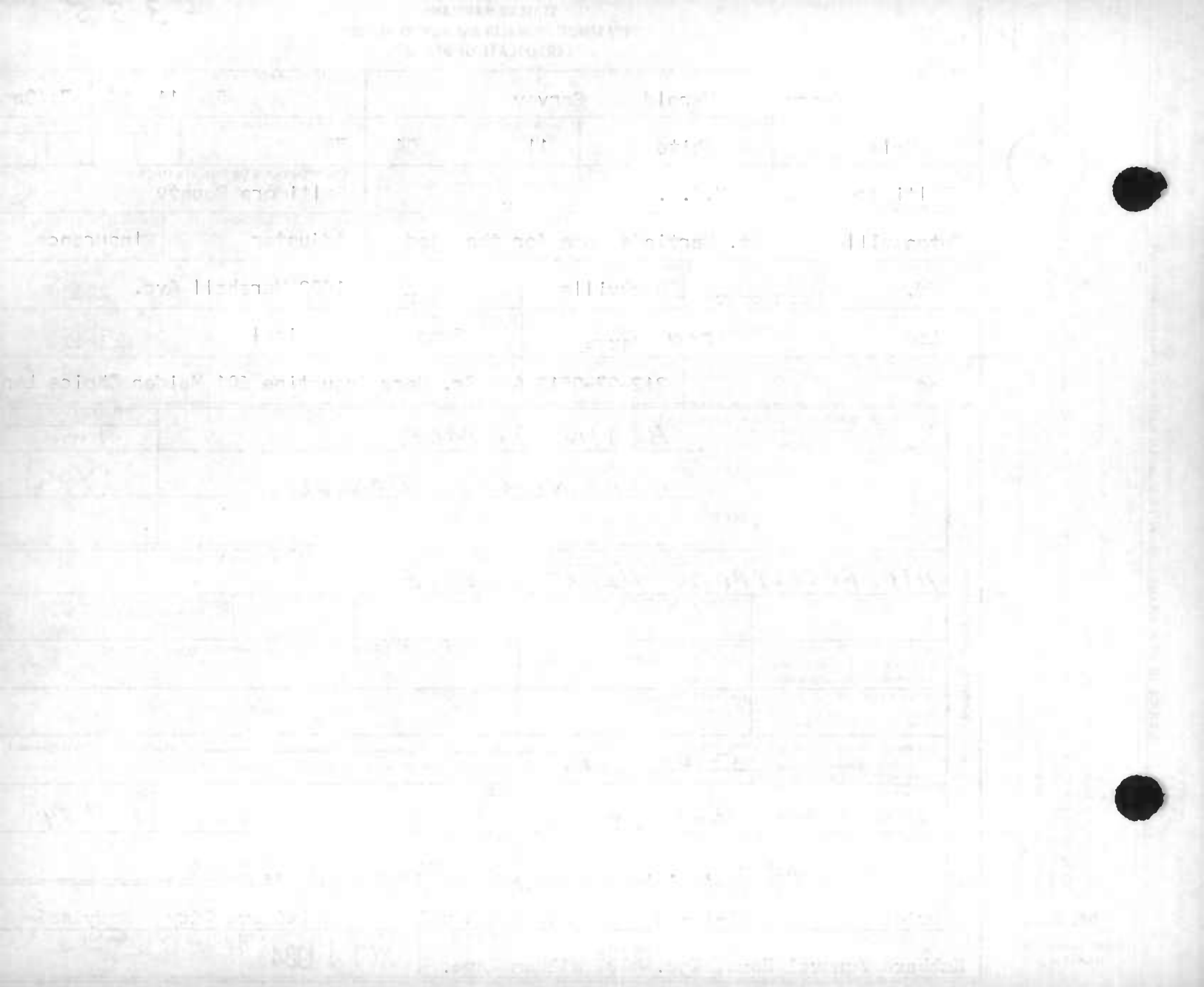
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director for PAGE 3, should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GLADYS TILLIE GEDDES</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 3, 1984</b>  |  | 2b. HOUR P M<br><b>10:35 P M</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12/13/1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.<br><b>89</b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO., MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>PARKSIDE HGTS.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FERRING PARKWAY NURSING HOME</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CHURCH OFFICE</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ROBERT P. C. SCHEIDT</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>TILLIE A. ENGLEHARDT</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216.05.8706</b>  |  | 17. INFORMANT ADDRESS<br><b>ELISE H. DAVIS 3122 GRINDON AVENUE BALTIMORE, MARYLAND 21214</b>  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4292 Acute C&amp;A</b><br>IMMEDIATE CAUSE (a) <b>Acute C&amp;A</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic card. &amp; atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Serumemia</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Gracia V. Patricio</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5/4/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gracia V. Patricio</b>  |  |   |  | 22e. ADDRESS<br><b>2926 E. COLD SPRING LANE BALTO., MD.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>5/4/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAY 4 1984 John Davidson-Randall</b>   |  |   |  |

BP \_\_\_\_\_

10:35 MAY 3, 1964

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WHITE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                     |
|---|--|---|---|---|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elisabeth G. GEISSLER       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 28, 1984   |   | 2b. HOUR<br>9:55A M |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 2, 1909   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.    |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |   |                     |
| 10. CITY OR TOWN OF DEATH<br>Kingsville   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>11202 Towood Road 21087 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.                     |                     |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |                     |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>-----   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>124 S. Highland Avenue 21224      |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph J. Geissler                            |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret W. Elberth                            |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>212-07-0609   |   | 17. INFORMANT<br>ADDRESS<br>Gertrude Novicki 1320 Walters Ave 21239 |                     |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

1749

IMMEDIATE CAUSE (a) *Metastatic breast cancer*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

16 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

## MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January</i> , 19 <i>84</i> , to <i>May 28</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>May 25</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><i>Paul Chang, M.D.</i>   | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><i>5/29/84</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Chang, M.D.   |  | 22e. ADDRESS<br>Good Samaritan Hospital Baltimore, Maryland  |  |

|  |                         |   |   |
|--|-------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial        | 23b. DATE<br>June 1, 84 | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc. |                         | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.               | 25a. DATE REC'D. BY REGISTRAR<br>MAY 31 1984                    |
|  |                         |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>     |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |   |  |   |  |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles H. Geist</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 25 84</b>                             |   |  | 2b. HOUR<br><b>3:55 PM</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 21 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dulaney Towson Nurs. Home</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Purina Mills</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Upperco</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>15208 Old Hanover Road 21155</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John E. Geist</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah F. Akehurst</b>         |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW2 492-09-2306</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Edward P. Geist, Upperco, Md.</b>           |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Cerebral Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Generalized ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 hrs</b><br><b>5 ± yrs</b> |  |   |   |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic Pressure Congestion of Lungs</b>  |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (the physician) attended the deceased from <b>1/14, 1984 to 25 May 1985</b> , that (we) lost saw the deceased alive on <b>24 May 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Charles O'Donnell</b>   |  |   | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/25/84</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Charles O'Donnell</b>  |  |   | 22e. ADDRESS<br><b>5501 York Rd.</b>  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>5-28-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Geist Cemetery</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Reisterstown Baltimore</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Eline Funeral Home, Hampstead, Md. 21074</b>  |  |   | ADDRESS   |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 29 1984</b>  |   |  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Yolanda M. George</b>                            |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-18-84</b>   |   | 2b. HOUR<br><b>8:30</b> M  |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 1, 1899</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hungary</b>                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dietitian</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. CITY OR TOWN<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>Dulaney Valley Rd. 21204</b>                                  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stephen Buday</b>                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marishka Vizuary</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>          |  | 16b. SOCIAL SECURITY NO.<br><b>215-30-3719</b>  |   | 17. INFORMANT<br>ADDRESS <b>105 Othoridge Rd.<br/>Mr. Paul B. Siegmund, Lutherville, Md. 21093</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4280 Cerebral Thrombosis**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/16</b> , 19 <b>83</b> , to <b>5/18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>5/18/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eddie NAKHUDA Md.</b>  |  | 22e. ADDRESS<br><b>2540 Dulaney Valley Rd.</b>                         |  |  |  |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE KEY)<br><b>Burial</b>                           | 23b. DATE<br><b>5-22-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Mem. Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>             |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MAY 23 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 20. DATE OF DEATH MONTH DAY YEAR 26 HOUR  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Herman C. Gibson  |  |   |  | May 29, 1984 4:30 P.M.  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 25, 1920  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CO. MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Forest Haven Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Groom  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Race Track   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Howard   |  | 13c. CITY OR TOWN<br>Laurel   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 13e. STREET ADDRESS<br>8851 Stephens Rd.  |  | 13f. CITY OR TOWN<br>Laurel   |  | 13g. STREET ADDRESS<br>8851 Stephens Rd.  |  | 20707   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ernest Gibson  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Louvenia ?  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>212-14-5538   |  | 17. INFORMANT ADDRESS<br>Mary A. Gibson (Wife) same as #13  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1509 IMMEDIATE CAUSE (a) Cancer of the esophagus<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1978, to 5-29, 1984, that (I) (we) lost saw the deceased alive on 5-15, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                               |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Harold B. Bob MD  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5/30/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>2220 Park Heights 21208  |  |   |  | 22e. ADDRESS<br>Harold B. Bob MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>6-2-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY<br>Laurel, Anne Arundel, Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>George R. Snowden  |  |   |  | 24b. ADDRESS<br>246 N. Washington St.<br>Rockville, Md. 20850   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 4 1984   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Jana Davidson   |  |   |  |

BP



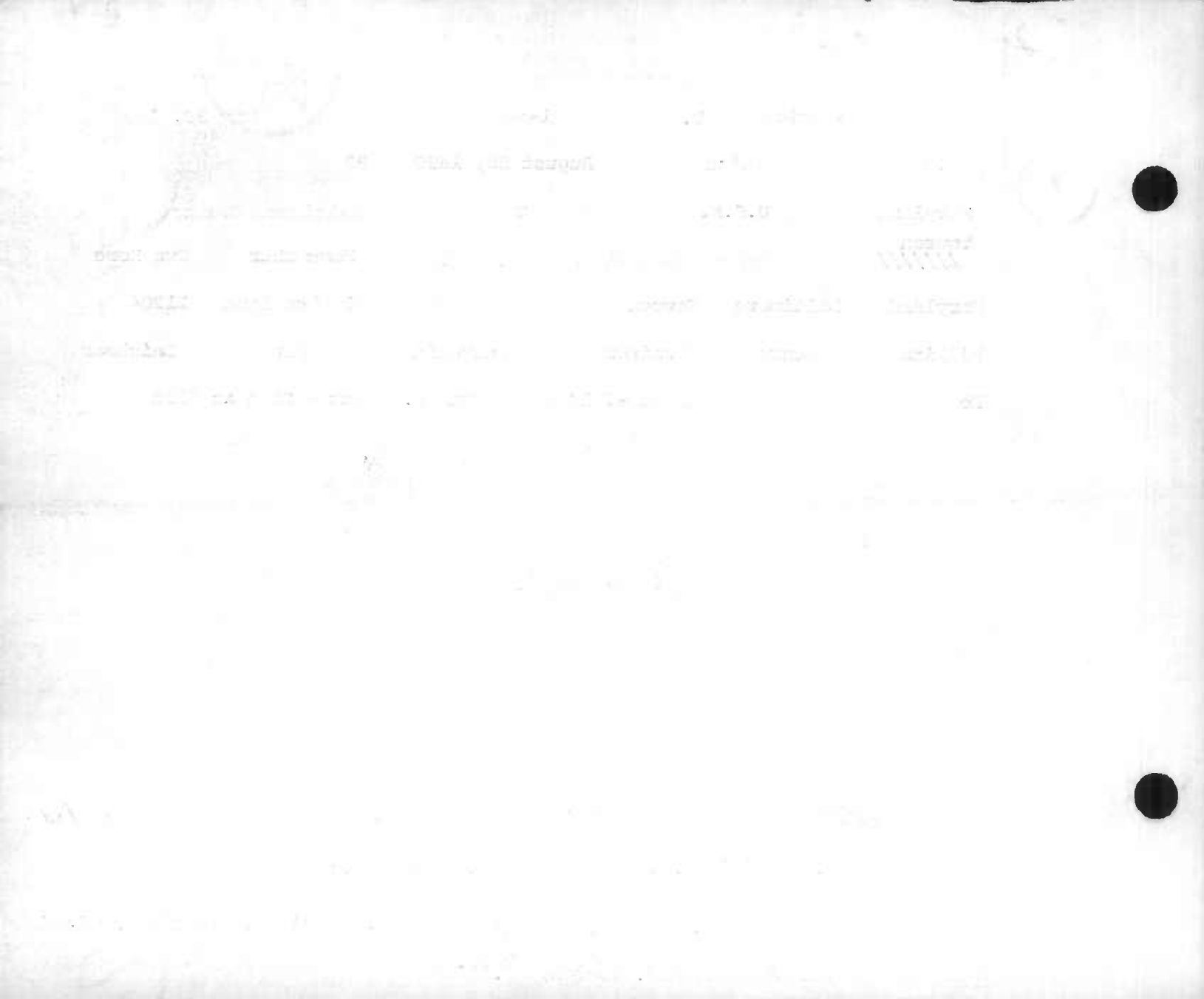
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Beatrice T. Giese</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 30, 1984</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>August 28, 1890</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>   |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Towson Nursing Home</b>   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                       |  | 13. STREET ADDRESS / ZIP CODE<br><b>41 Theo Lane 21204</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Henry Trainor</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lucretia Ann Leishear</b> |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |
| 17. SOCIAL SECURITY NO.<br><b>216-32-7014 D</b>   |  | 18. INFORMANT ADDRESS<br><b>Rebekah B. Wyatt - Same as #13e</b>            |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>1539 Metastatic Carcinoma of Colon</b><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Anemia</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Gracito V. Patricio M.D.</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>5/30/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gracito V. Patricio M.D.</b>  |  | 22e. ADDRESS<br><b>6217 Harford Road</b>                                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6-1-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Augustine Cemetery</b>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Elkridge, Howard, Maryland</b>  |  | 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc.</b>         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1984</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  | 25c. REGISTRAR'S NAME<br><b>[Signature]</b>                                |  |   |  |



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |
|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM J. GILLELAND JR.</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MAY 18 1984</b>  |  | 2b. HOUR<br>M   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 4 1922</b>  |  | 6. AGE<br>(IN YEARS (LAST BIRTHDAY))<br><b>61</b> YRS.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY</b> MD.                                 |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3420 LOGANVIEW DR.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FIREMAN</b> | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>DUNDALK</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wm GILLELAND SR.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AGNES RAUSCH</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-18-3874</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>RUBY JEAN GILLELAND</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute arrest - Cardiac</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)                   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> , 19 <b>84</b> , to <b>3</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |
| 22b. SIGNATURE<br><b>Theoc Patterson MD</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>5/19/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THEOC PATTERSON</b>  |  | 22e. ADDRESS<br><b>3427 Dundalk Ave 2122</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/22/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART</b>                          |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>CONNELLY FUNERAL HOME OF DUNDALK</b>   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



EXHIBIT - 1 - 1917

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                                  |   |   |   |
|--|----------------------------------|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>OSCAR GLAZEROW</b>   |                                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>5/21</b> 19 <b>84</b> |   | 2b. HOUR<br><b>3:24</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>          | 5. DATE OF BIRTH<br>MONTH <b>NOV.</b> DAY <b>6,</b> YEAR <b>1913</b>                              | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>70</b> YRS.                             | 7. IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>   |                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>  |                                  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |   |   |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2819 MARNAT RD., 2nd FL.</b>  |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OWNER</b>                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GROCERY STORE</b>   |
| 13a. STATE<br><b>MARYLAND</b>  |                                  | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST <b>MAX</b> MIDDLE <b>GLAZEROW</b> LAST <b></b>  |                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNIE</b> MIDDLE <b>BULK</b> LAST <b></b>                    |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |                                  | 16b. SOCIAL SECURITY NO.<br><b>217-14-6626A</b>   |   | 17. INFORMANT <b>MRS. BELLE GLAZEROW</b><br><b>2819 MARNAT RD. BALTO., MD 21209</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9525</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                                  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Vascular Disease</b>   |                                  |   |   |   |
| 19a. DATE OF OPERATION   |                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                  |   |   |   |
| ACTUAL SIGNATURE <b>Stanley Z. Feltenberg</b>  |                                  | TITLE (SPECIFY)<br><b>MD.</b>   |   | DATE SIGNED <b>5/27/84</b>  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>STANLEY Z. Feltenberg MD.</b>   |                                  | ADDRESS <b>11 E. Chase St. 21202</b>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>MAY 29, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI ZION</b>   | 23d. LOCATION<br>CITY OR TOWN<br><b>ROSEDALE</b>                              | COUNTY<br><b>BALTO.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |                                  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 31 1984</b>  |   |   |
| 26. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>                                       |   |   |

UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," it follows any injury, or other traumatic event, the medical examiner must be notified immediately.

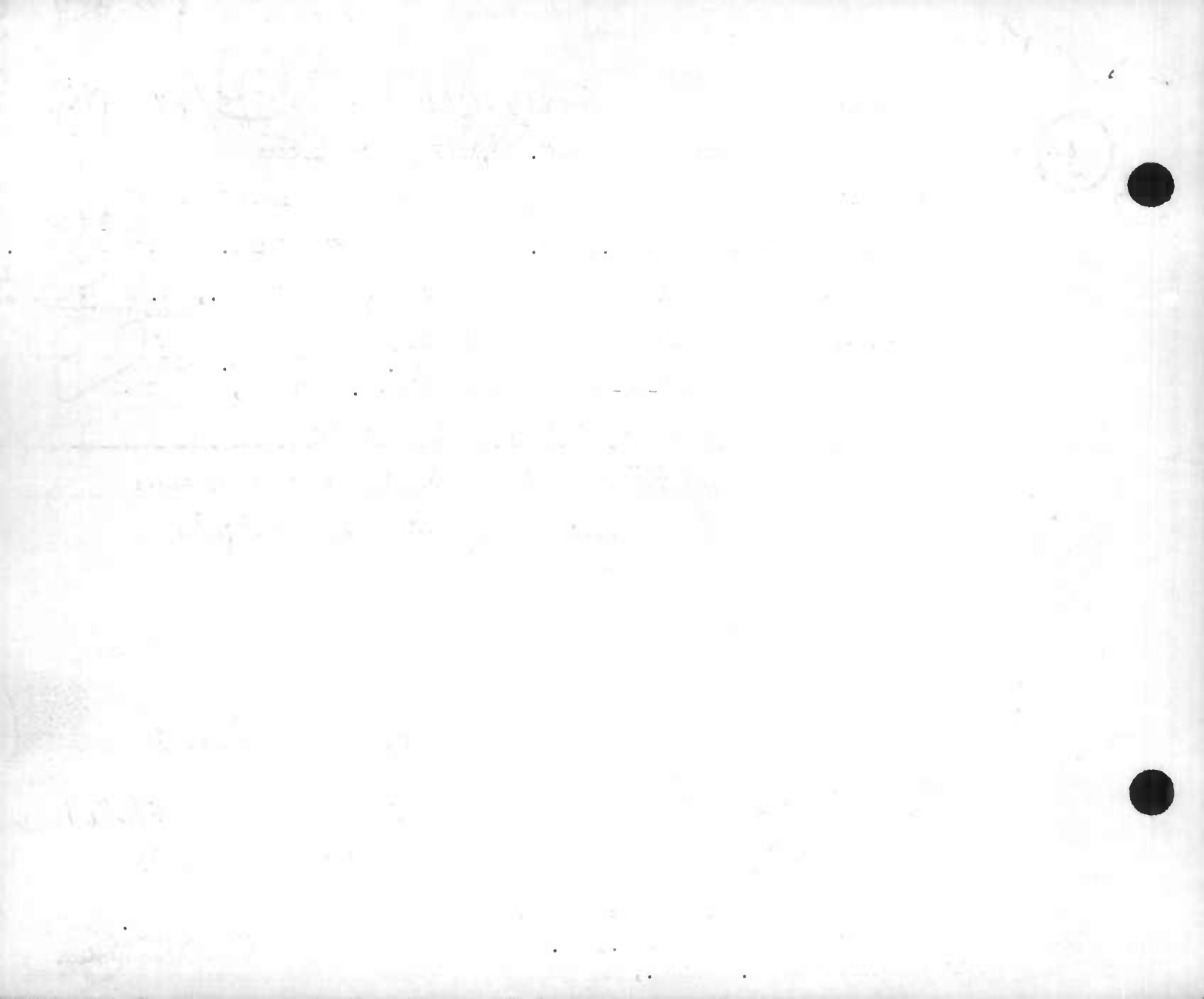
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |   |   |  |  |
|---|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Israel</i>   |  |  | 2a. DATE OF DEATH<br>MONTH <i>5</i> DAY <i>5</i> YEAR <i>1984</i>         |  |  | 2b. HOURS <i>4</i> P <i>1750</i> M  |   |  |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>WHITE</i>  |   | 5. DATE OF BIRTH<br>MONTH <i>NOV.</i> DAY <i>26</i> YEAR <i>1897</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>86</i> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS <i>xx</i> DAYS <i>xx</i> HOURS <i>xx</i> MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>PENNSYLVANIA</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE COUNTY</i> MD.                             |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>6624 SANZO RD., APT. D</i> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>COURT STENO.</i>         |   | 12b. BUSINESS INDUSTRY<br><i>SUPREME BENCH</i><br>CITY OF BALTO.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |   |   |  |  |
| 13a. STATE<br><i>MARYLAND</i>   |  | 13b. COUNTY<br><i>BALTIMORE</i>  |   | 13c. CITY OR TOWN<br><i>BALTIMORE</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><i>6624 SANZO RD., APT. D #21209</i>   |  |
| 14. FATHER'S NAME<br>FIRST <i>JULIUS</i> MIDDLE <i></i> LAST <i>GOLDMAN</i>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>BESSIE</i> MIDDLE <i></i> LAST <i>COHEN</i> |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>215-34-1341</i>   |   | 17. INFORMANT <i>MRS. JACQUELINE S. G. ZAPPALA</i><br><i>1901 SUNRISE DR. POTOMAC, MD 20854</i>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4100 Anterograde myocardial infarct - coronary artery</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>hypertensive arteriosclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>chronic congestive heart failure, chronic renal failure</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>  |  |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i></i> P.M. <i>19</i> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1919</i> to <i>Present</i> , that (I) (we) lost<br>saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Charles S. Angell, M.D.</i>  |  |  | DEGREE  |  |  | 22c. DATE SIGNED<br><i>5/6/84</i>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>C.S. ANGELL, M.D.</i>   |  |  | 22e. ADDRESS<br><i>611 Park Ave. 21201</i>                                |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>  |  | 23b. DATE<br><i>MAY 7, 1984</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>HAR SINAI</i>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>OWINGS MILLS BALTO. MD</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>SOL LEVINSON &amp; BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 8 1984</i>  |   |  |  |
|   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                                     |   |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |  |   |  |  |
|--|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY R. GOLORESS</b>   |  |   | 2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>4</b> YEAR <b>1984</b>                  |   |   | 2b. HOUR <b>6:30 A.M.</b>  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>DEC.</b> DAY <b>11</b> YEAR <b>1899</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS                                       |   | 7. UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERIDIAN NURSING HOME</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES CLERK</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTO.</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>JACOB</b> MIDDLE <b></b> LAST <b>COHEN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LENA</b> MIDDLE <b></b> LAST <b>ZELDITCH</b> |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1002 BITTERSWEET RD. 21208</b>                    |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-20-9775A</b>                                   |   | 17. INFORMANT <b>MRS. HARRIET HUMMEL</b><br><b>1002 BITTERSWEET RD. BALTO. MD 21208</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line. List all, but only one.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Stroke: ASCVD, CAs</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acc. V.D.F.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1979</b> to <b>April 1984</b> , that (I) (we) last saw the deceased alive on <b>April 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE <b>BABU RAO, M.D.</b> DEGREE  |  |   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5.4.84.</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BABU RAO, M.D.</b>   |  |   |   |   | 22e. ADDRESS<br><b>8811 LIBERTY RD. RANDALLSTOWN, MD 21133</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>MAY 6, 1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH</b>   |  | 23d. LOCATION<br>CITY <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>                                   |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BRUS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 - 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |  |

MEDICAL CERTIFICATION

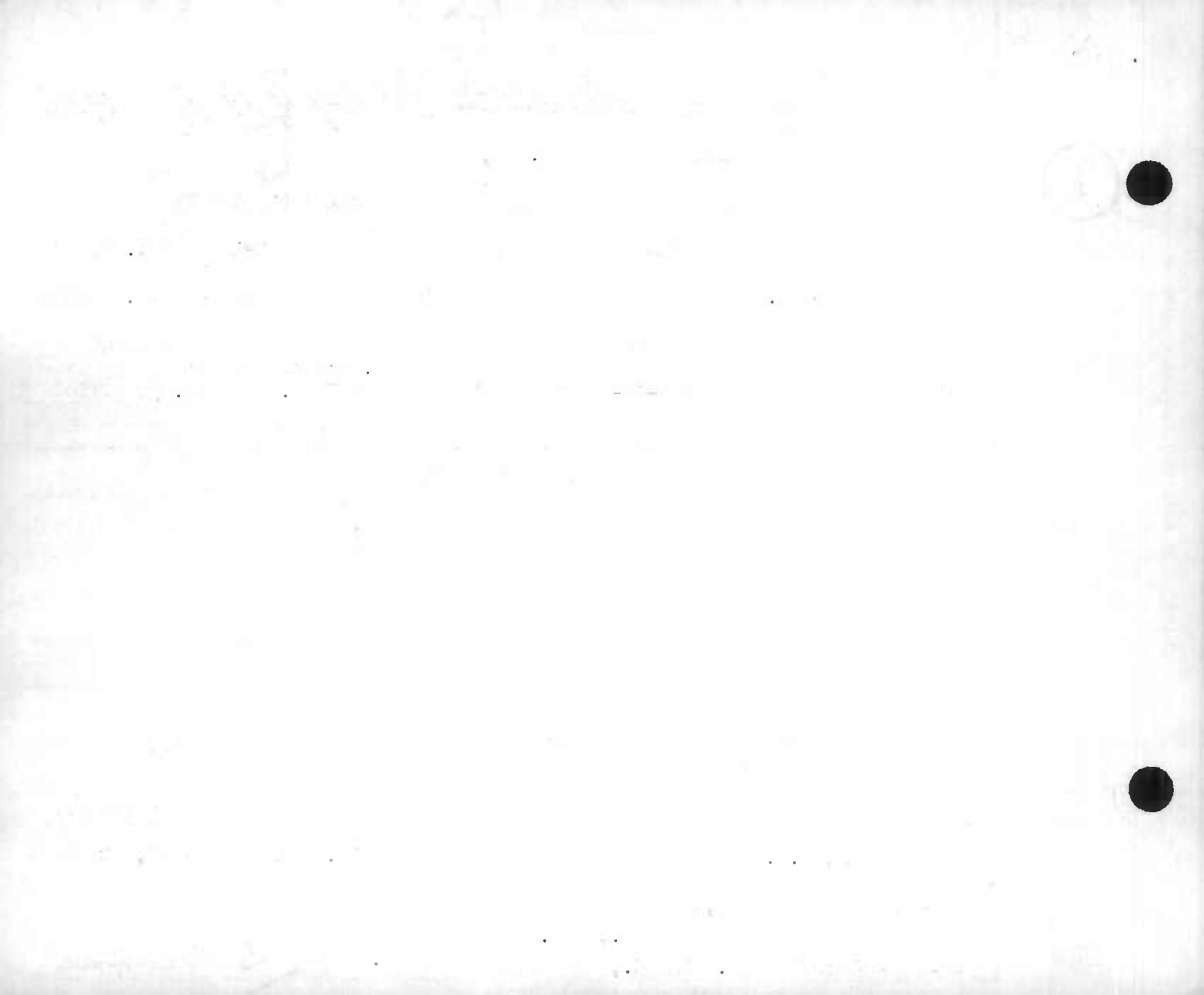
9  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

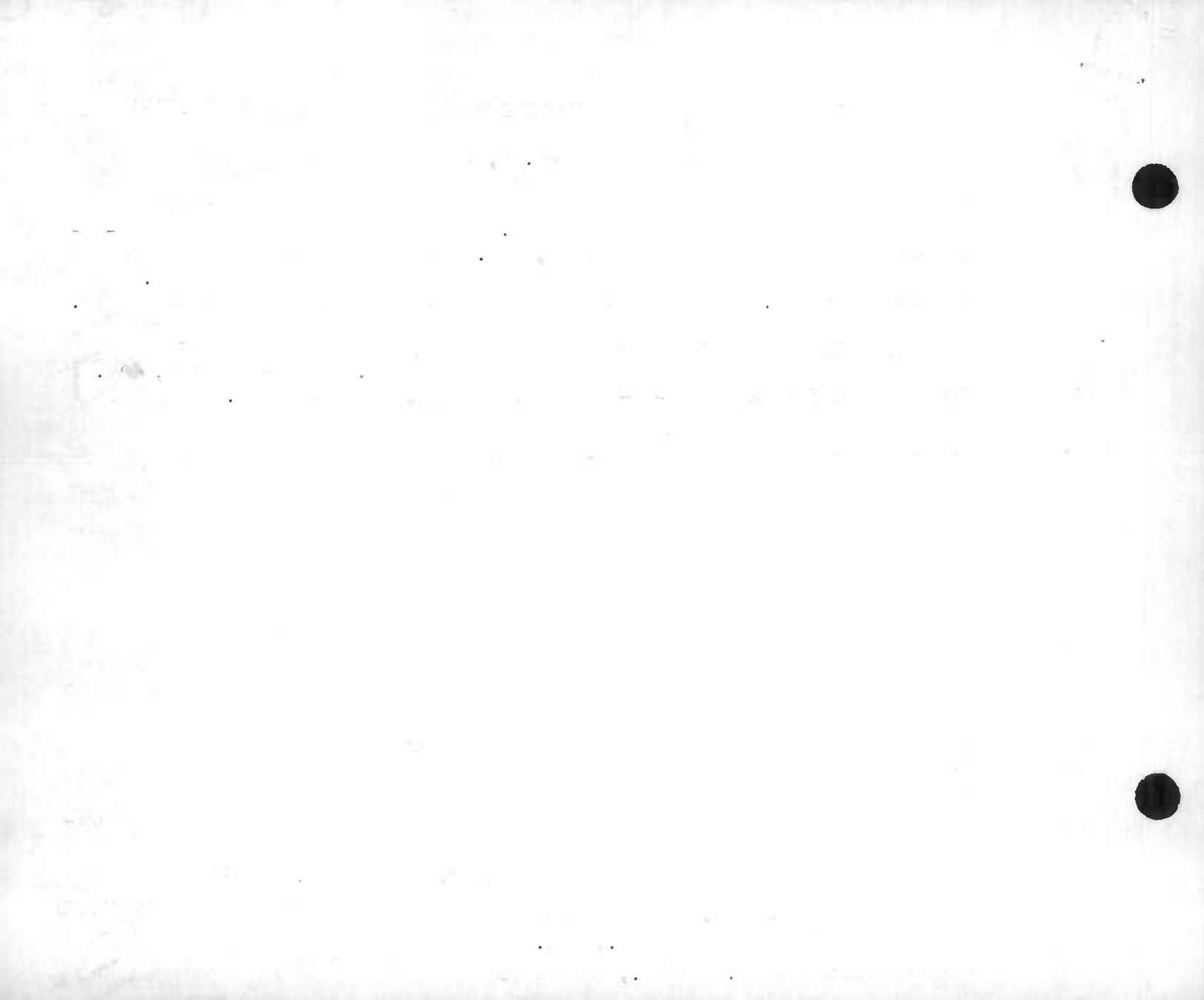
|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELI GOLDSMITH   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 19, 1984 |   |  | 2b. HOUR A M<br>8 AM  |  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 6, 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CIR.<br>7916 DUNHILL VILLAGE, APT. 102 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPERVISOR                  |  | 12b. PREVIOUS OCCUPATION<br>MERRY GO ROUND ENTERPRISES  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7916 DUNHILL VILLAGE CIR. APT. 102 #21207                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MORRIS GOLDSMITH  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA ROSENBERG   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII=ARMY 219-28-6285  |  | 17. INFORMANT<br>MRS. ELENA GOLDSMITH, APT. 102<br>7916 DUNHILL VILLAGE CIR. #21207             |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ischemic cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary artery disease</u>   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>10 year</u><br><u>15 year</u> |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Diabetes mellitus</u>  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/16/84</u> 19 <u>84</u> to <u>Present</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>5/16/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Bernard Tabatznik M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>5/19/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARD TABATZNIK  |  |   |  | 22e. ADDRESS<br>2724 N. CHARLES ST. #21218  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>MAY 21, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO  |  | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 23 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

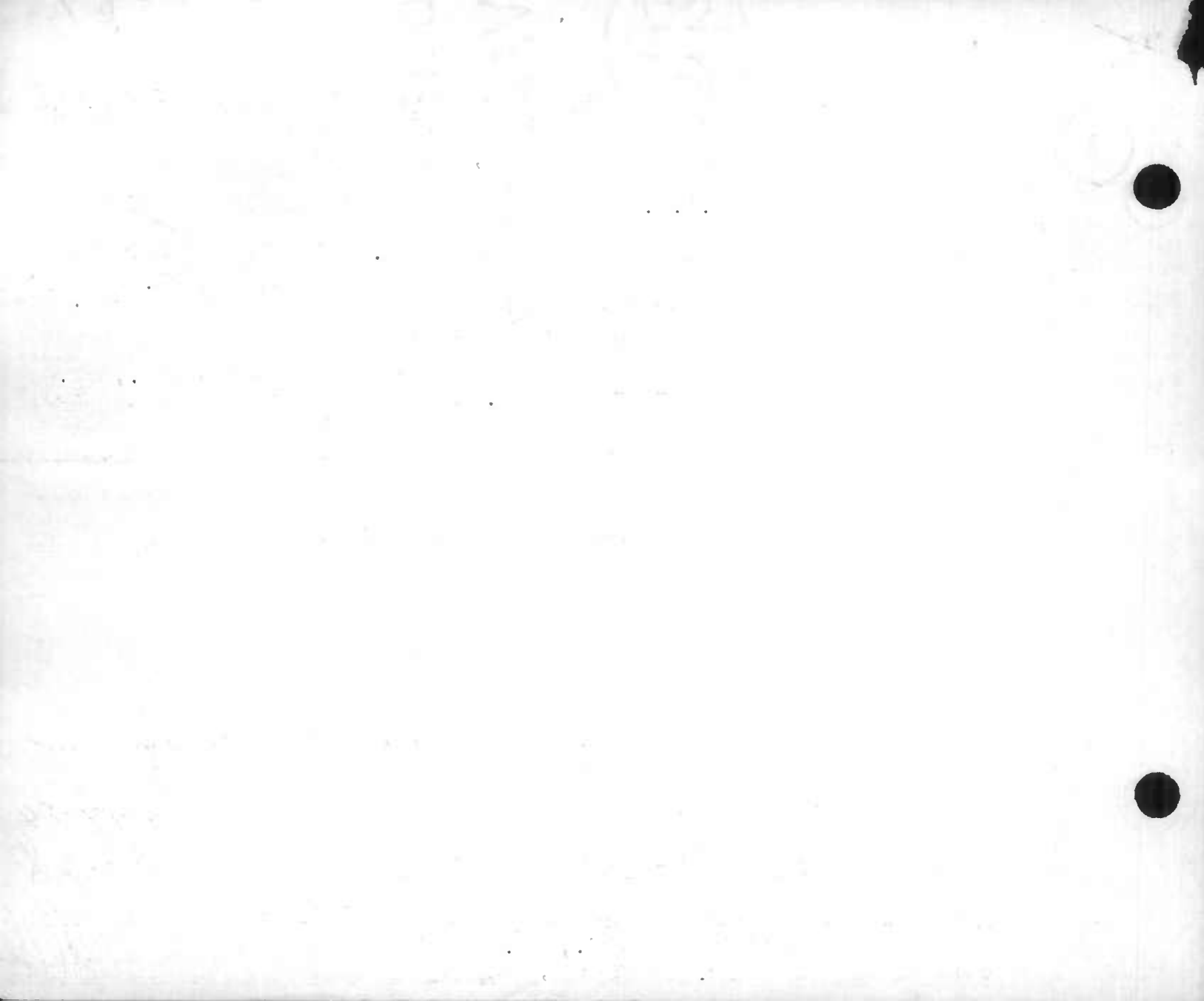
REG. NO.

|  |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY GOLDSTEIN</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-17-84</b>   |   |  |   | 2b. HOUR<br><b>11:55</b> AM  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 3, 1903</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>ROMANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GENERAL HOSP.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRODUCE</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NOAH GOLDSTEIN</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BEATRICE UNKNOWN</b>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>050-14-7945</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>6504 PARK HEIGHTS AVE. APT. B (21215)</b><br><b>MRS. LOTTIE GOLDSTEIN</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>prostate cancer with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>cerebrovascular accident</b> |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-27-</b> 19 <b>84</b> , to <b>5-17-</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5-17-</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Soon Chul Hong</b>  |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5-17-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOON CHUL HONG</b>   |  |  | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>               |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>REMOVAL-BURIAL</b>  |  |  | 23b. DATE<br><b>5/20/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW AID CEM</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WAWARSING NEW YORK</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>            |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendell</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

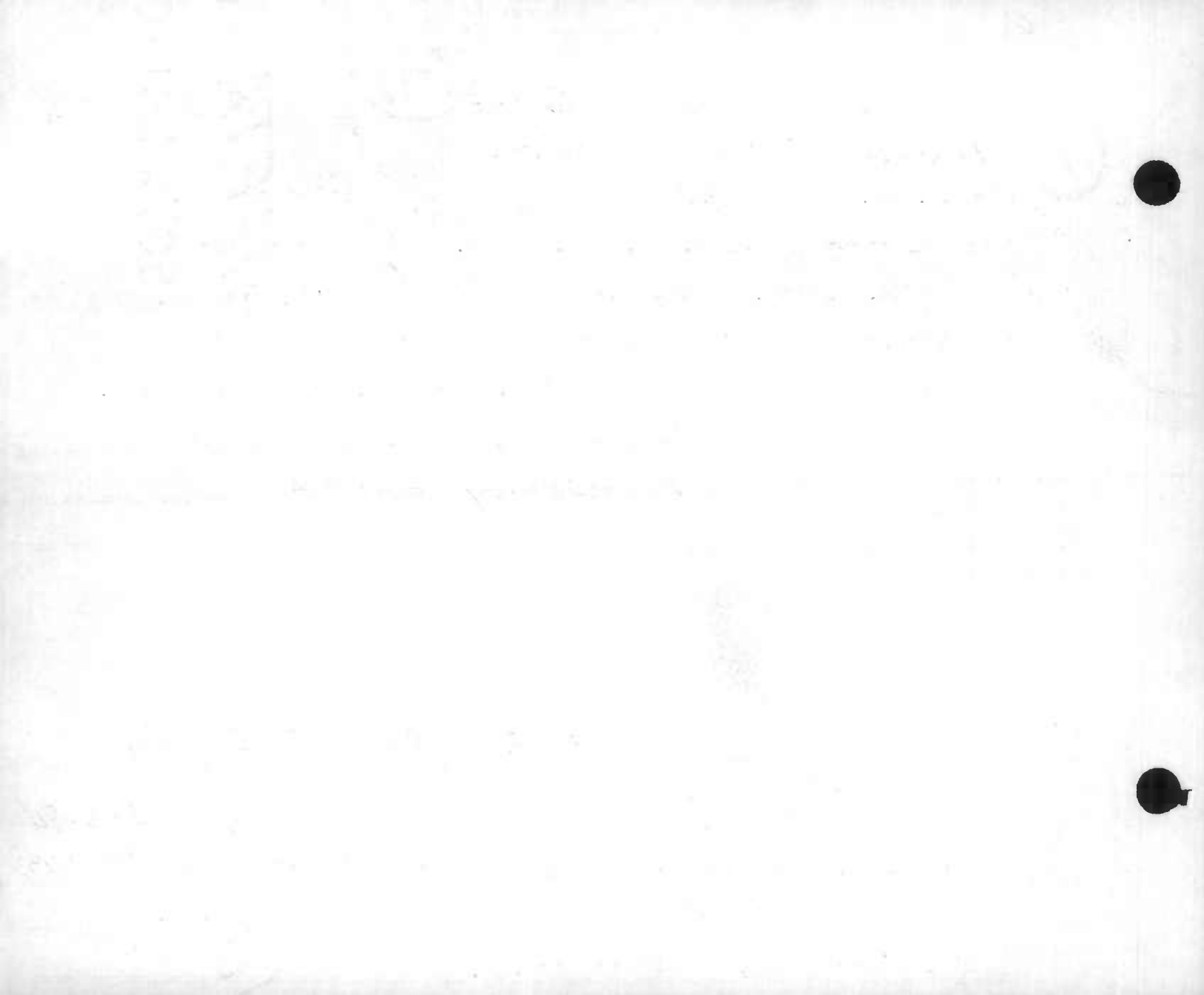
|   |  |  |  |   |   |  |  |  |   |                  |  |  |
|---|--|--|--|---|---|--|--|--|---|------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDNA O. GORE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-5-84</b>                   |   | 2b. HOUR<br><b>3 16 AM</b>                                      |  |  |  |   |                  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 21, 1923</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD  |  |  |   |                  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Gen. Hospt.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                  |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Glyndon</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>49 Railroad Ave. 21071</b> |                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vernon Steffee</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Smith</b>  |   |   |  |  |  |   |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-16-871</b>                          |   | 17. INFORMANT ADDRESS<br><b>Mr. Vernon B. Gore Glyndon, Md.</b> |  |  |  |   |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO - RESPIRATORY ARREST</b><br><b>5140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |  |  |   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |  |  |  |   |   |  |  |  |   |                  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |   |                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-5</b> 19 <b>84</b> to <b>5-5</b> 19 <b>84</b> that (I) (we) lost<br>saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |   |                  |  |  |
| 22b. SIGNATURE<br><b>Orlando B. Cowan</b>   |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>5-5-84</b>                               |                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ORLANDO B. COWAN MD</b>   |  |  | 22e. ADDRESS<br><b>BEGH - RANDALLSTOWN Md. 21133</b>                   |   |   |  |  |  |   |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK IF)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>May 8, 84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                  |  |   |                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Reisterstown, Md.</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

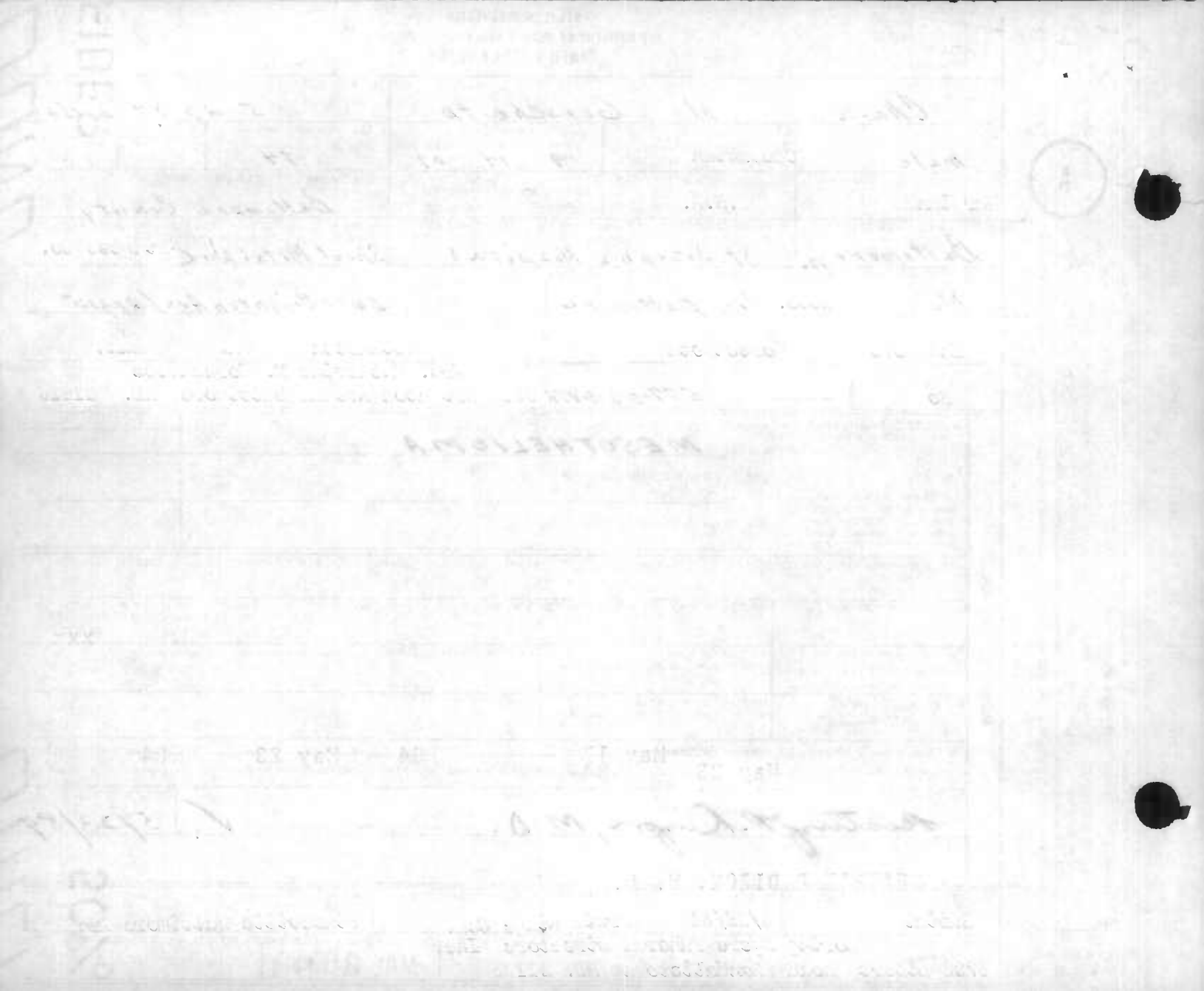
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   |  | REG. NO.   |  |
|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Charles W. Gorschboth</i>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 23 84</i>   |  | 2b. HOUR<br><i>8:18A M</i>   |  |
| 3. SEX<br><i>male</i>  | 4. RACE<br><i>Caucasian</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 14 09</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County MD.</i>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore Co.</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Joseph's Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Sheet Metal Worker</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Fingles Co.</i>  |  |
| 13a. STATE<br><i>Md</i>  |   |   | 13b. COUNTY<br><i>Balto. City</i>   | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Theodore Gorschboth</i>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Elizabeth K. Huhn</i>                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>577-03-0873</i>   |   | 17. INFORMANT<br>NAME ADDRESS<br><i>Mrs. Katherine M. Gorschboth</i><br><i>6610 Brighton Avenue Baltimore, MD. 21215</i> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>MESOTHELIOMA</i><br><i>1991</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.    |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>XXX</i> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased on <i>May 17</i> , 19 <i>84</i> , to <i>May 23</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>May 23</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Beatriz P. Dizon, M.D.</i>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><i>5/23/84</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>BEATRIZ P. DIZON, M. D.</i>  |   | 22e. ADDRESS  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  | 23b. DATE<br><i>5/26/84</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge Cem.</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Pikesville Baltimore MD.</i>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Loring Byers Funeral Directors, Inc.</i><br><i>8728 Liberty Road Randallstown, MD. 21133</i>  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 25 1984</i>  |  |  |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Galia Davidson-Randall</i>  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.


|   |   |   |   |  |  |  |  |
|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST MIDDLE LAST   |   | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| Mary Minnie GRANRUTH  |   |   |   | May 19, 1984   |  | 12:30P M   |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| F   | W   | 5/3/99  |   | 85 YRS.  |  |  |  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| MD.   | USA   |   |   | Baltimore County, MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| ROSSVILLE   | FRANKLIN SQ. HOSP.  |   |   | HSWK   |  |  |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS  |  |  |  |
| MD.   | BALTO   | MIDDLE RIVER  |   | 709 WAMPLER RD 21220   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |  |  |  |
| JOSEPH DALEY  |   | MINNIE KUNGER   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |  |  |
| NO  |   | UNK   |   | ROBERT GRANRUTH ABOVE  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Asystole<br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 17, 1984, to May 19, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 19, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br>Michael Delahunt  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5/19/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Delahunt, M.D.   |   |   |   | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| BURIAL  |   | 5/22/84   |   | MT. CARMEL   |  | BALTO. MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |   |   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Connelly F.H. of Essex 300 More ave.  |   |   |   | MAY 22 1984  |  | Selia Davidson-Randall   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |   |  |  |  |  |   |  |
|--|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Theresa J. Green  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 2, 1984              |  |  | 2b. HOUR<br>9:10 P.M.  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 11 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                  |  |   |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Eastpoint Nursing Home |   |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Practical Nurse             |  | 15. KIND OF BUSINESS OR INDUSTRY<br>Nursing   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Md.  |  | 17. COUNTY<br>-   |   | 18. CITY OR TOWN<br>Baltimore  |  | 19. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20. STREET ADDRESS / ZIP CODE<br>401 N. Streeper St. 21224  |  |
| 21. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Rimbak   |  |   | 22. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Weber |  |  | 23. ADDRESS<br>118 N. Ellwood Ave.<br>Frank J. Rimbak (nephew) 21224                           |  |   |  |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  | 25. SOCIAL SECURITY NO.<br>215-12-5331A   |   | 26. INFORMANT<br>118 N. Ellwood Ave.<br>Frank J. Rimbak (nephew) 21224   |  |  |  |   |  |
| 27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4960 IMMEDIATE CAUSE (a) Cardio-Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Dis.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hrs year |  |   |   |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Anterior communicating artery aneurysm - lry dry cerebral  |  |   |   |  |  |  |  |   |  |
| 28. DATE OF OPERATION  |  | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 30. AUTOPSY<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  | 31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 32. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 33. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 35. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 36. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 37. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 38. I certify that (I) (this hospital) attended the deceased from Jan 19 19 84 to May 2 19 84, that (I) (we) lost<br>saw the deceased alive on May 1 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |  |   |  |
| 39. SIGNATURE<br>Dr. Bienvenido Matos  |  |   |   | 40. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 41. DATE SIGNED<br>5/4/84  |  |   |  |
| 42. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Bienvenido Matos   |  |   |   | 43. ADDRESS<br>Yorktowne Village, 21 Cranbrook Rd.   |  |  |  |   |  |
| 44. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 45. DATE<br>5/7/84  |   | 46. NAME OF CEMETERY OR CREMATORY<br>Baltimore Nat'l   |  | 47. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  | 48. DATE REC'D. BY REGISTRAR<br>MAY 4 1984  |  |
| 49. FUNERAL DIRECTOR<br>NAME Schimunek Funeral Home, Inc.<br>ADDRESS 3331 Brehms Lane, Balto. Md. 21213  |  |   |   |  |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 7 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |   |  |   |          |   |                       |
|--|--|--|--|---|--|---|--|---|--|---|----------|---|-----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>MARIE Elizabeth   |  | MIDDLE<br>Griffin   |  | LAST<br>Griffin   |  | 2a. DATE OF DEATH   |  | MONTH<br>5  | DAY<br>7 | YEAR<br>84                                  | 2b. HOUR<br>3:40 P.M. |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH  |  | MONTH<br>7  |  | DAY<br>5  |  | YEAR<br>01  |          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE County MD |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired School Teacher |  | 12b. KIND OF BUSINESS OR INDUSTRY   |          |   |                       |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Valley View Nursing Home |  | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  | 13b. COUNTY<br>BALTIMORE                                    |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET ADDRESS<br>2908 White Ave 21214 |                       |
| 14. FATHER'S NAME  |  | FIRST<br>Thomas  |  | MIDDLE<br>Griffin   |  | LAST<br>Griffin   |  | 15. MOTHER'S MAIDEN NAME  |  | FIRST<br>Mary   |          | MIDDLE<br>A LAST<br>Saffran                 |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>220-14-3170  |  | 17. INFORMANT<br>Mr David Simmons   |  | ADDRESS<br>5718 Harford Rd 21214                            |  |   |  |   |          |   |                       |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute myocardial infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hours<br>years |  |
|--|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Patrick K. PATRICKO  |  |  |  |  |  | 22c. DATE SIGNED<br>5/8/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Patrick K. PATRICKO   |  |  |  |  |  | 22e. ADDRESS<br>2926 E. Cold Spring La Baltimore, Md   |  |

|   |  |                      |  |   |  |   |  |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial |  | 23b. DATE<br>5/10/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
|---|--|----------------------|--|---|--|---|--|

|   |  |                         |  |  |  |  |  |
|---|--|-------------------------|--|--|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard A. Buck |  | ADDRESS<br>5305 HUNTERD |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 10 1984 |  | REGISTRAR'S SIGNATURE<br>John Davidson-Randall |  |
|---|--|-------------------------|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

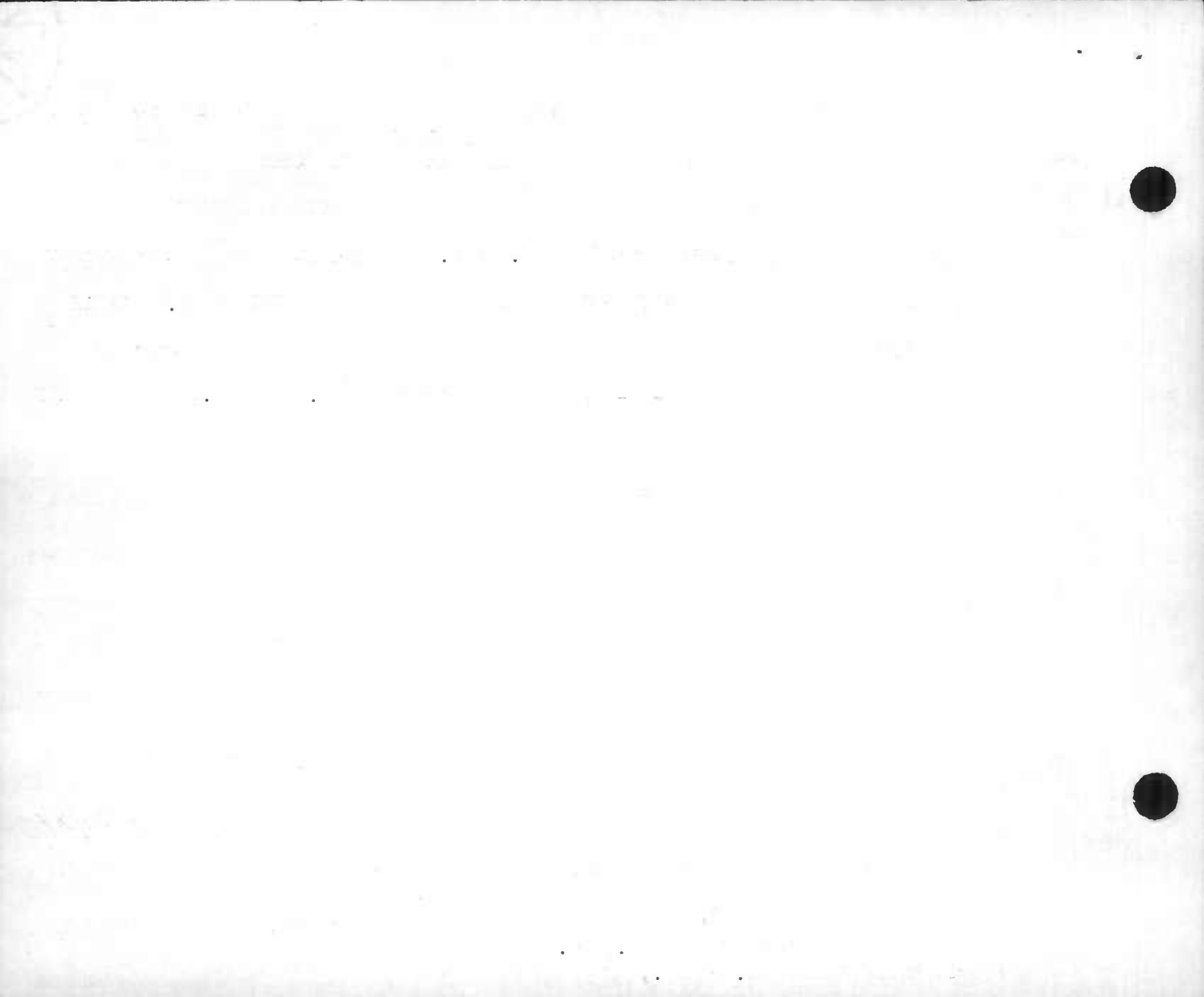
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  | REC. NO.  |  |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MORRIS GROSS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 21 84</b>   |  | 2b. HOUR<br><b>9<sup>03</sup> P.M.</b>                  |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 23 06</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BARBER</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COSMETOLOGY</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MARYLAND BALTIMORE</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4211 LABYRINTH RD. 21215</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY GROSS</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b>                           |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-5177A</b>   |   | 17. INFORMANT<br><b>MELVIN GROSS</b><br><b>4211 LABYRINTH RD. BALTO., MD 21215</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-17</b> , 19 <b>84</b> , to <b>5-21</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5-21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Raymond Depestre</b>  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/21/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYNOLD DEPESTRE</b>   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSP.</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>MAY 23, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD, BALTO., MD 21215  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 25 1984</b>  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |  |   |   |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |   | REG. NO.  |  |
|---|--|--|--|---|--|---|---|--|---|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |   |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EDWARD LYELL GUNTS</b>  |  |  |  |   |  |   |   |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br><b>May 7 1984</b> |  |
| 2. SEX<br><b>Male</b>   |  |  |  |   |  |   |   |  |   | 2b. HOUR<br><b>9P</b>   |  |
| 3. RACE<br><b>White</b>   |  | 4. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 25, 1914</b> |  | 5. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 YRS.</b>           |  | 6. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |   | 7c. DATE PRONOUNCED DEAD<br><b>May 7 1984</b>                                    |   | 7d. HOUR<br><b>9P</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Commercial Artist</b>       |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Advertising</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>317 Worthington Road 21204.</b>       |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Lyell Gunts, Sr.</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Faye Parker</b>   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-03-0998</b>              |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Grace C. Gunts 317 Worthington Road</b>   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029 Cardiac Arrest</b><br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>Hypertensive ASCVD</b><br>(b) <b>Hypertensive ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>5 days</b> |  |  |  |   |  |   |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .  |  |  |  |   |  |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b>   |  |  |  | TITLE (SPECIFY)<br><b>Deputy</b>                            |  |   |   | MEDICAL EXAMINER<br>DATE SIGNED<br><b>5/8/84</b>                                 |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Charles F. O'Donnell</b>   |  |  |  | ADDRESS<br><b>7501 York Road 21212</b>                      |  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>May 11, 1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto. Co., Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 10 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                      |   |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR STATE REGISTRAR  |  | STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | CERTIFICATE OF DEATH  |  | REG. NO.  |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary M Halpin</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-18-84</b>   |  | 2b. HOUR<br><b>6:40<sup>A</sup></b>   |  |   |  |
| 1. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 18 27</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1113 Chatterleigh Circle 91204</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Fohner</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Russell</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 24 5657</b>  |  | 17. INFORMANT<br><b>W. Gregory Halpin</b> ADDRESS<br><b>Same</b>        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5672</b> IMMEDIATE CAUSE (a) <b>Probable sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Subacute purulent peritonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/24</b> , 19 <b>84</b> , to <b>5/18</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Samuel H. Lee, M.D.</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel C. H. Lee, M.D.</b>   |  | 22e. ADDRESS<br><b>St. Joseph Hospital, Baltimore, MD 21204</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>5/21/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto Md</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John W. Anderson</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |  |   | REG. NO.<br>2376  |   |  |  |                           |
|--|---|---|--|---|---|---|--|--|---------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Baby Boy Hammitt</b>   |   |   |  |   | 7a. DATE OF DEATH MONTH DAY YEAR <b>5 29 84</b>             |   |  |  | 7b. HOUR <b>7-30 A.M.</b> |
| 3. SEX <b>M</b>  | 4. RACE <b>B</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 29 84</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>2 6</b>                       |   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                             |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>                  |   |   |  |  |                           |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |  |   | 13a. STREET ADDRESS / ZIP CODE <b>330 E. 20th St. 21218</b> |   |  |  |                           |
| 13a. STATE <b>U.S.A.</b>   | 13b. COUNTY <b>Baltimore</b>  | 13c. CITY OR TOWN <b>Towson</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |   |  |  |                           |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>— — —</b>   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beverly Hammitt</b>                            |   |   |   |  |  |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>—</b>   |   |   | 16b. SOCIAL SECURITY NO. <b>—</b>  |   | 17. INFORMANT ADDRESS <b>—</b>                              |   |  |  |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7650 Non-viability</b><br>IMMEDIATE CAUSE (a) <b>7650</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>7650</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>7650</b>  |   |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>  |   |   |  |   |   |   |  |  |                           |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5-29 19 84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |   |   |  |  |                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |  |                           |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>5-29 19 84</b> , to <b>5-29 19 84</b> , that (X) (we) last saw the deceased alive on <b>5-29 19 84</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. |   |   |  |   |   |   |  |  |                           |
| 27b. SIGNATURE <b>S. A. Sinnar</b>   |   | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 27c. DATE SIGNED <b>5-29-84</b>   |   |   |  |  |                           |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Z. A. SINNAR</b>  |   | 27e. ADDRESS <b>St. Joseph Hosp. 7620 York Rd 21204</b>   |  |   |   |   |  |  |                           |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Hosp. Removal</b>   |   | 23b. DATE <b>5-29-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>                                |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>  |  |  |                           |
| 24. FUNERAL DIRECTOR NAME <b>St Joseph Hospital 7620 York Road Towson md 21204</b>   |   |   |  | 25a. DATE RECEIVED BY REGISTRAR <b>JUN 4 1984</b>                                 |   |   |  |  |                           |
| 25b. REGISTRAR'S SIGNATURE <b>G. Davidson</b>  |   |   |  |   |   |   |  |  |                           |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
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REGISTRAR

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles Larimore Hampton</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 29, 1984</b>                           |   | 2b. HOUR<br>M                                       |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 17, 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MINS.       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tenn.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.,</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Broadmead</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Executive</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Banking</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>   |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Benjamin Hampton</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estella Larimore</b>             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>252 28 3354</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Shirley H. Wilson 14 W. Franklin St.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Hypertension</b>   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 22a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT HOME  |   | 22b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 22c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22d. I certify that (I) (this hospital) attended the deceased from <b>3/23/82</b> 19 <b>MD</b> to <b>5/29</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/23/84</b> 19 <b>MD</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.    |   |   |  |   |   |
| 22e. SIGNATURE<br><b>[Signature]</b>  |   | DEGREE  |  | 22f. DATE SIGNED<br><b>5/30/84</b>  |   |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F. SANZARO</b>  |   | 22h. ADDRESS<br><b>Broadmead</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 23a. <del>TYPE</del> CREMATION <del>OR</del> BURIAL   |   | 23b. DATE<br><b>5/31/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cem.</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |   | 23e. DATE REC'D. BY REGISTRAR   |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>  |   | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE<br><b>JUN 1 1984 [Signature]</b>   |  |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

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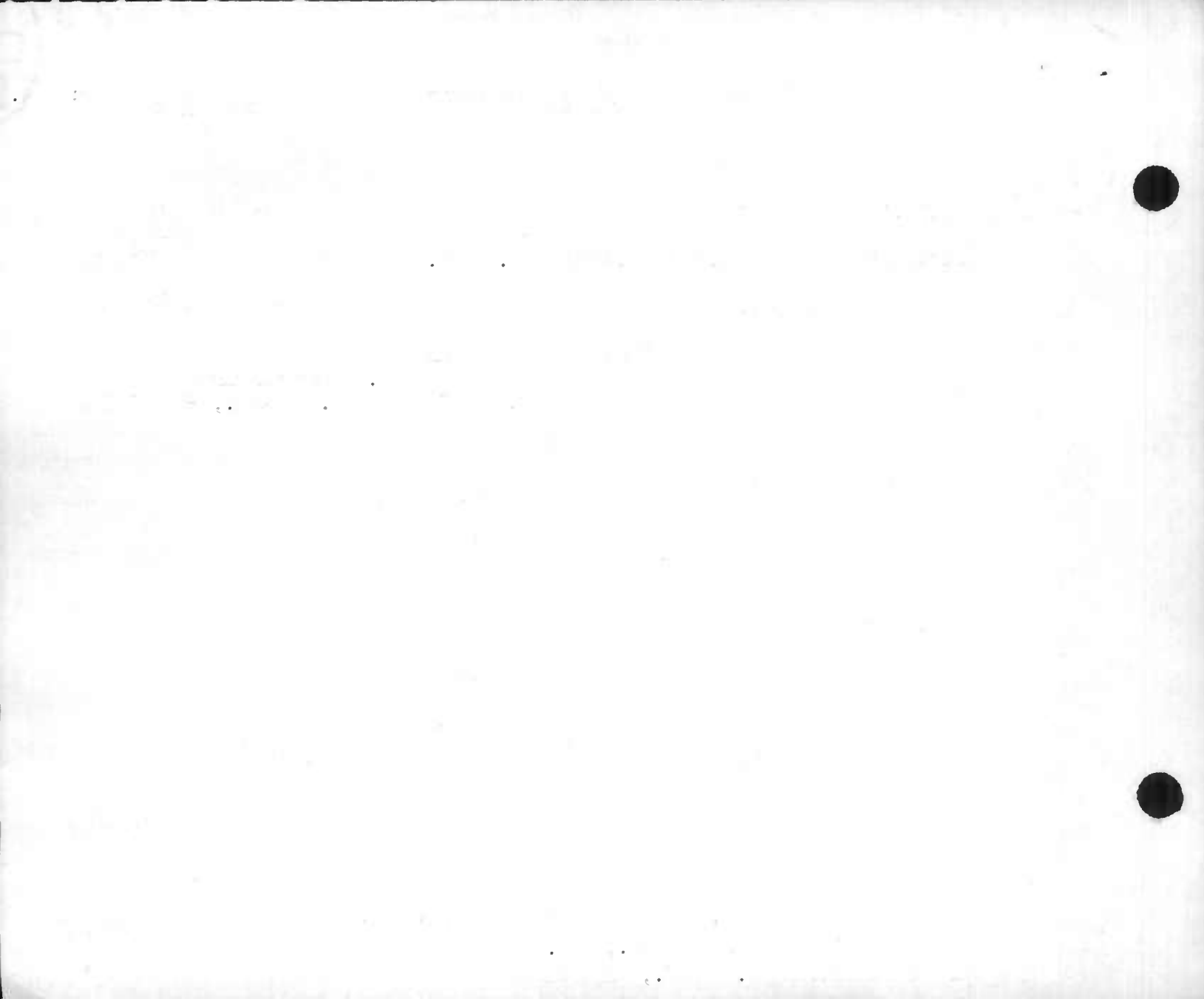
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | REG. NO.  |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL</b> <b>HANDLEMAN</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-22-84</b>   |   | 2b. HOUR<br>MIN. <b>12:10 A.</b>                                |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 26 1918</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MERCHANT</b>                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>  |   |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>XXXXXXX</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   | 13e. STREET ADDRESS / ZIP CODE<br><b>6016 Highgate Dr 21215</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MARCUS HANDLEMAN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY UNKNOWN</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII=MARINES 064 09 5595</b>  |   | 17. INFORMANT<br><b>MRS. SELMA HANDLEMAN</b><br><b>6016 HIGHGATE DR. BALTO., MD 21215</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CA of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>4/19/84</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of Lung</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/21/84</b> , 19____, to <b>5/22/84</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>5/21/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |   |   |   |   |   |
| 22b. SIGNATURE<br><b>with bell us</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>5/22/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>with bell us</b>   |   | 22e. ADDRESS<br><b>BCH 521-2200</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   | 23b. DATE<br><b>MAY 23, 1984</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH ISAAC ADATH ISRAEL</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALT., MD 21215</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 25 1984</b><br>25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b> |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret L HANSEN</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 27, 1984</b>  |  | 2b. HOUR<br><b>7:13A</b> M   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-26-1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, City</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County,</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Karl Dittmar</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Bau</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-4091D</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. John D. Hansen -7919 32nd St. -21237</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 hour</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><b>Multifactorial Stroke; Gout.</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>5/13/84</b> to <b>5/27/84</b> , that (I) (we) lost saw the deceased alive on <b>5/13/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Albert B. Bruchy</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>5/28/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>5-30-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John C. Miller Inc</b> ADDRESS <b>6415 Belair Rd. -21206</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 31 1984</b>   |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |  |  |

John P. Miller Inc. 417 Columbia Rd. 2005  
7-10-78

2-10-7

• *Handwritten notes:*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMITS. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 7a. DATE KNOWN OF DEATH                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Alvin Harris  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |
| 3 SEX Male 4 RACE Negro 5. DATE OF BIRTH MONTH DAY YEAR Dec. 31, 54 6 AGE (IN YEARS LAST BIRTHDAY) 29 YRS. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  |  |  |  |  |  |  |  |  | 7c. DATE PRONOUNCED DEAD May 5-10 19 84                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. |  |
| 10. CITY OR TOWN OF DEATH Randallstown 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer 12b. KIND OF BUSINESS OR INDUSTRY Construction   |  |  |  |  |  |  |  |  |  | 24. HOUR 1:08 P.M.   |  |
| USUAL RESIDENCE (IF IN MISSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 2452 E. Eager St. 21205   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph B. Harris 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Redd  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 214628808 17. INFORMANT ADDRESS Estelle Harris/2452 E. Eager St.   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9259 IMMEDIATE CAUSE (a) Electrocution<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30xx 5-10 19 84 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject came in contact with live wire   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house 21f. LOCATION CITY OR TOWN COUNTY STATE 9924 Hoyte Circle, Randallstown, Balto. Co., Md.  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 5-11-84   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 5-16-84 23c. NAME OF CEMETERY OR CREMATORY Baltimore 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore -- Maryland   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR Marshall W. Jones, Jr. 4101 Edmondson Ave. 25a. DATE REC'D. BY REGISTRAR MAY 14 1984 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |

12

SECRET  
OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301

MEMORANDUM FOR THE SECRETARY OF DEFENSE  
SUBJECT: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE SECRETARY OF DEFENSE: [Illegible]

UNCLASSIFIED

13 JUL 1984

13 JUL 1984

13 JUL 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BERTHA <del>WARRIS</del> HARRIS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 2, 84  |  | 2b. HOUR<br>3:44 A.M.  |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 28, 1907 <sup>AR</sup>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77<br>YRS.                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASS.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN. HOSP. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>2900 TERRY RD., APT. B #21209                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>AARON MEYERS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DEBORAH BERMAN   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-42-0721  |   | 17. INFORMANT<br>DEBORAH HARRIS<br>7354 PARK HTS. AVE. BALTO., MD 21208        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary heart failure</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerotic Cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1984</u> to <u>May 2, 1984</u> , that (I) (we) lost<br>saw the deceased alive on <u>May 2, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Ghassem Pounmotabbed</u>   |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>5-2-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GHASSEM POUNMOTABBED   |  | 22e. ADDRESS<br>Balto. County Gen. Hospital   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>MAY 3, 1984   | 23c. NAME OF CEMETERY OR CREMATORY<br>SHAAREI ZION  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD               |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John R. ...</u>   |

1949



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

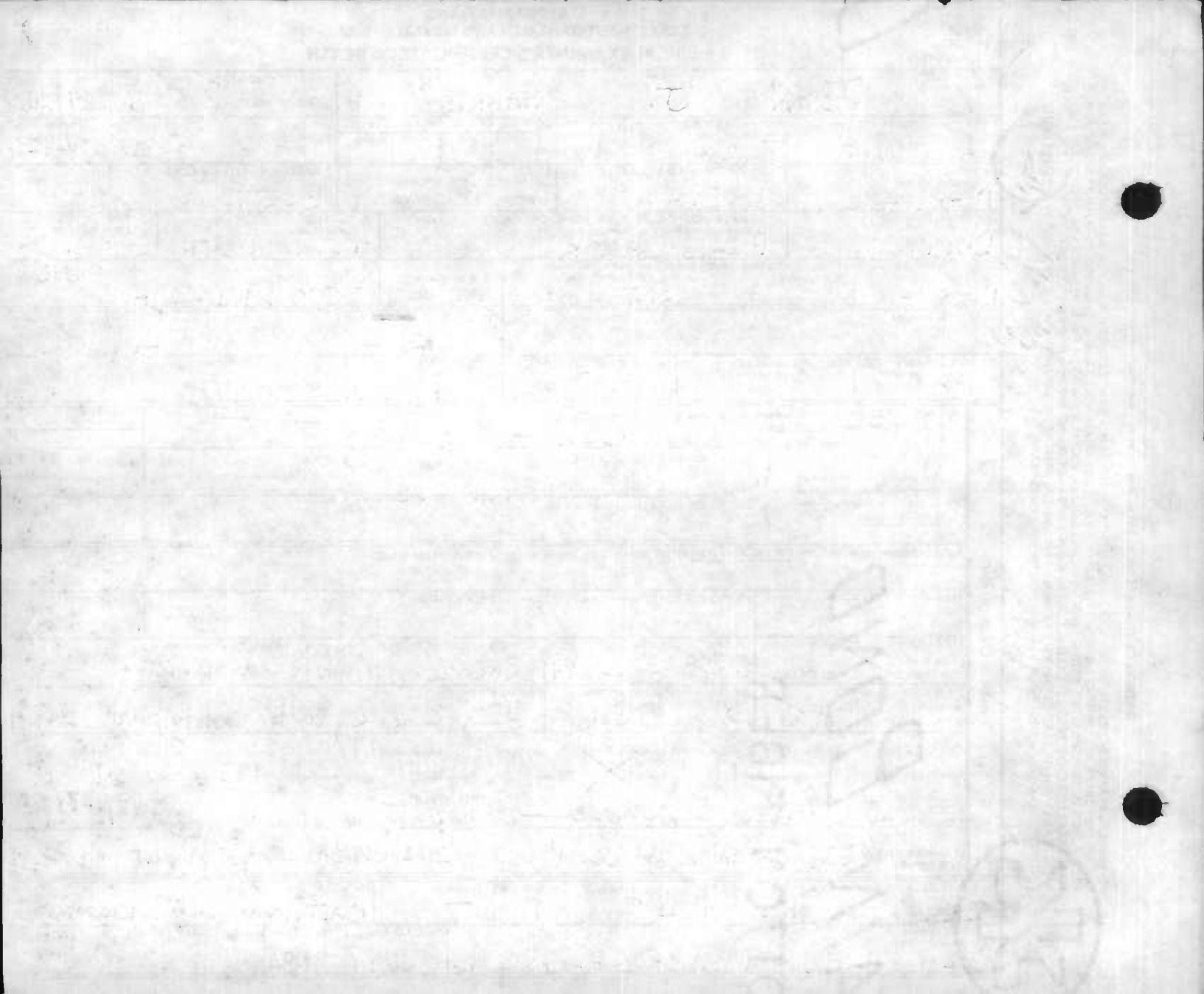
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |   |  |  |  |              |  |                  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|--|--|--------------|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>JOHN  |  | MIDDLE<br>J.  |  | LAST<br>HARRIS   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  | MONTH<br>5  |  | DAY<br>26                              |  | YEAR<br>1984 |  | 2b. HOUR<br>2030 |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 24 1957  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>26 YRS.                              |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                    |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH<br>5                             |  | DAY<br>27    |  | YEAR<br>1984     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.               |  | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WATER DEPT. |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BALTO. CITY  |  |  |  |              |  |                  |  |
| 11. CITY OR TOWN OF DEATH<br>DUNDALK  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BEAR CREEK |  | 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3500 LYNDAL AVE |  | 21213        |  |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S NAME<br>FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>219-62-7457                                    |  | 17. INFORMANT<br>FAMILY RECORDS   |  | ADDRESS<br>ADDICKS  |  |  |  |              |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9102 IMMEDIATE CAUSE (a) <u>Submission + drowning</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |  |  |   |  |  |  |   |  |   |  |  |  |              |  |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |  |  |   |  |  |  |   |  |   |  |  |  |              |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |  |  |              |  |                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2030 @ 5 26 1984  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8 PART 1 OR PART 2)<br>Submerged while swimming  |  |  |  |   |  |   |  |  |  |              |  |                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Bear Creek  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Bear Creek, Balt. County, Md. 21214  |  |  |  |   |  |   |  |  |  |              |  |                  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |   |  |  |  |   |  |   |  |  |  |              |  |                  |  |
| ACTUAL SIGNATURE<br>J. Crossan O'Donovan  |  | TITLE (SPECIFY)<br>Deputy  |  | M.D.  |  | MEDICAL EXAMINER   |  | DATE SIGNED<br>5/27/84  |  |   |  |  |  |              |  |                  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>J. CROSSAN O'DONOVAN  |  | ADDRESS<br>2112 DUNDALK AVE, BALTO., MD. 21221   |  |   |  |  |  |   |  |   |  |  |  |              |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION   |  | 23b. DATE<br>MAY 31 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GROSSA MOUNT  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTIMORE MARYLAND |  |   |  |   |  |  |  |              |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS CHAPLAIN OF MEMORIES HARFORD RD.  |  | ADDRESS<br>8800  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 1 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Harrison Andell                         |  |   |  |   |  |  |  |              |  |                  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 8 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KATHRYN E. HARSCH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 13 84</b>                  |   | 2b. HOUR P<br><b>12:58</b>   |  |   |  |  |
| 3. SEX<br><b>Fem.</b>   |  | 4. RACE<br><b>Cau.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 19 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                            |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES ST</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C &amp; P Telephone</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Timonium</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Evans</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Rhiem</b> |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2117 Reuter Rd. Md. 21093</b>                             |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-03-6385</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Edward J. Harsch 2117 Reuter Rd.</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARIOPULMONARY ARREST</b><br><br>1749 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC BREAST CARCINOMA</b><br><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CEREBRAL HEMORRHAGE</b> |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-10</b> , 19 <b>84</b> to <b>5-13</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5-13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Timothy Herlihy</i>  |  |   | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/13/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TIMOTHY HERLIHY</b>   |  |   | 22e. ADDRESS<br><b>GBMC 6701 N CHARLES ST, TOWSON MD</b>               |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>5-18-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zanesville Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Zanesville Ohio</b>                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc. 6415 Belair Rd.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1984</b>  |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner with the verbal autopsy.

100-100-100

100-100-100  
100-100-100  
100-100-100

100-100-100 100-100-100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

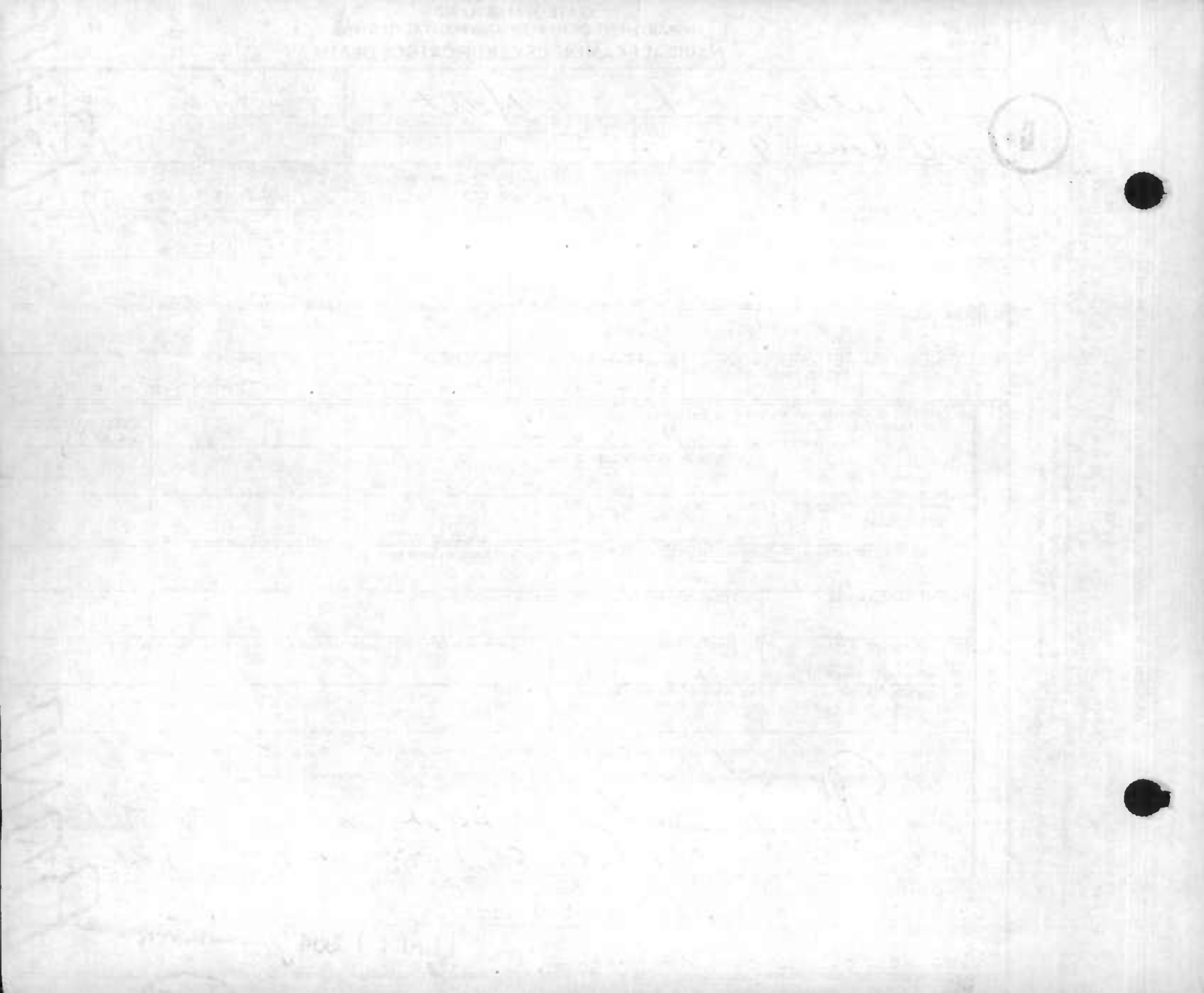
DMMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |                     |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|---------------------|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Ruth</i>  |  |  | FIRST <i>R</i>      |  |  | MIDDLE <i>K</i>   |  |  | LAST <i>Hart</i>  |  |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <i>5</i> DAY <i>11</i> YEAR <i>1984</i>                                      |  |  | 2d. HOUR <i>1 P.</i>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX <i>Female</i>   |  |  | 4. RACE <i>Cauc</i> |  |  | 5. DATE OF BIRTH<br>MONTH <i>9</i> DAY <i>5</i> YEAR <i>07</i>  |  |  | 6. AGE (IN YEARS)<br>MONTHS <i>76</i> YEARS <i>YRS.</i> |  |  | IF UNDER 1 YR.<br>MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i>   |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <i>5</i> DAY <i>11</i> YEAR <i>1984</i> |  |  | 7d. HOUR <i>1 P.</i>   |  |  |  |  |  |  |  |  |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Owings Mills, Md.</i>   |  |  |                     |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  |   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>   |  |  |                     |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Balto. Co. Gen. Hospt.</i> |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired Nurse</i>   |  |  |   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><i>Md.</i>   |  |  |                     |  |  | 13b. COUNTY<br><i>Balto.</i>  |  |  |   |  |  | 13c. CITY OR TOWN<br><i>Owings Mills</i>  |  |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  | 13e. STREET ADDRESS<br><i>1 Church Road</i>                            |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <i>Sylvester</i> MIDDLE <i>V.</i> LAST <i>King</i>  |  |  |                     |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Minerva</i> MIDDLE <i></i> LAST <i>Nelson</i>  |  |  |   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>No</i>  |  |  |   |  |  | 16b. SOCIAL SECURITY NO.<br><i>217-32-8780</i>                                       |  |  |  |  |  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Jessie K. DuChane Owings Mills</i> |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ASCVD</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>   |  |  |                     |  |  |   |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>9 years</i>                       |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |                     |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |                     |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  |   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |                     |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M.</i> <i>19</i>  |  |  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |                     |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |                     |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><i>S. Williams</i>   |  |  |                     |  |  | TITLE (SPECIFY)<br><i>Deputy</i>  |  |  |   |  |  | DATE SIGNED<br><i>5/11/84</i>   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><i>E. P. Williams</i>  |  |  |                     |  |  | ADDRESS<br><i>5850 BAYVIEW NAT L PK 21228</i>   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>   |  |  |                     |  |  | 23b. DATE<br><i>May 12, 84</i>  |  |  |   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Memorial</i>  |  |  |   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i>                  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Eline Funeral Home</i>  |  |  |                     |  |  |   |  |  |   |  |  | ADDRESS<br><i>Reisterstown, Md.</i>   |  |  |   |  |  | 25a. DATE REC'D BY REGISTRAR<br><i>MAY 14 1984</i>                                   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                       |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 8 5

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>JOHN</b> MIDDLE <b>L.</b> LAST <b>HARTRANFT</b>  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>20</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>1159</b> <sub>M</sub>  |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>01</b> YEAR <b>11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Insurance Agent</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>       |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>Towson</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Hartranft</b> LAST <b>Ellen</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ellen</b> MIDDLE <b>Shanahan</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>326-07-5116A</b>   |  | 17. INFORMANT<br><b>Betty H. Hartranft-Same as #13e</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>AM. MYOCARDIAL INFARCT</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1715</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>5-20-84</b> to <b>5-20-84</b> , that (1) (yes) lost saw the deceased as stated above, (1) (no) did not see the body after death, 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |   |   |  |   |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5-20-84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>5-23-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium, Baltimore, Maryland</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>   |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |   | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1984</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |  |   |   |

BP



| State        | City      | Address             | Insurance Agent | Insurance Company |
|--------------|-----------|---------------------|-----------------|-------------------|
| Pennsylvania | BALTIMORE | ST. JOSEPH HOSPITAL | Insurance Agent | Insurance Company |
| Maryland     | BALTIMORE | Town                | Insurance Agent | Insurance Company |
| Charles      | BALTIMORE | Town                | Insurance Agent | Insurance Company |
| Yes          | Yes       | Yes                 | Yes             | Yes               |

Blank lines for additional entries.



| State        | City      | Address             | Insurance Agent | Insurance Company |
|--------------|-----------|---------------------|-----------------|-------------------|
| Pennsylvania | BALTIMORE | ST. JOSEPH HOSPITAL | Insurance Agent | Insurance Company |
| Maryland     | BALTIMORE | Town                | Insurance Agent | Insurance Company |
| Charles      | BALTIMORE | Town                | Insurance Agent | Insurance Company |
| Yes          | Yes       | Yes                 | Yes             | Yes               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |                            |   |  |   |  |  |  |
|---|--|---|---|--|----------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Francis X. Heaphy</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-22-1984</b> |  | 2b. HOUR<br>M<br><b>AM</b> |   |  |   |  |  |  |
| 1. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-15-1916</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. Co.</b> MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1636 Thetford Rd.</b> |   |  |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Proof Reader</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1636 Thetford Rd., 21204</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Edward Heaphy</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Alice Connolly</b>  |                            |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |   | 17. INFORMANT<br><b>Rose M. Hamilton</b>   |                            | ADDRESS<br><b>8722 Maravoss Ia. 21234</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>CARDIAC ARRHYTHMIA</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b). <b>CARDIOMYOPATHY, ISCHEMIC</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c). <b>CORONARY ARTERY DISEASE</b>   |  |   |   |  |                            |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>1 YR</b><br><b>—</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>   |  |   |   |  |                            |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                            |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |   |  |   |  |  |  |
| 22a. I certify that <b>0</b> (this hospital) attended the deceased from <b>5/19</b> , 19 <b>84</b> , to <b>5/22</b> , 19 <b>84</b> , that <b>0</b> (we) lost<br>saw the deceased alive on <b>5/19</b> , 19 <b>84</b> , and that in <b>0</b> (our) opinion death occurred on the date and hour and from the causes stated<br>above <b>0</b> (we) first and only view the body after death. |  |   |   |  |                            |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles F. Hoesch</b>  |  |   |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                            |   |  | 22c. DATE SIGNED<br><b>5/23/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles F. Hoesch, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>9712 Belair Rd.</b>   |                            |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-25-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>  |  |   |   |  |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 8 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUISE E. HEISE</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-15-84</b>  |  | 2b. HOUR<br><b>3:20</b> M  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 23 01</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE ROSSVILLE</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>MD</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>7928 Langdon Lane 21206</b>                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George P. Schreiber</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Brogely</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-09-3827</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. Henry A. Heise Same</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>3310 Alzheimer's disease</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b> yrs.</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>ASCVD</b>   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>- YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1984</b> to <b>5/15/84</b> , that (I) (we) last saw the deceased alive on <b>5:15pm 5/15/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |   |  |  |
| 22b. SIGNATURE<br><b>W. J. Tun</b>   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/15/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. Tun</b>  |  | 22e. ADDRESS<br><b>Manor Care Rossville</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 18, 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 18 1984</b>   |  |  |
|  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/interment permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a significant injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  |  |  | MONTH   |  | DAY  |  | YEAR   |  | 2b. HOUR                                     |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | May  |  | 2, 1984  |  | 2:26 PM                                      |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  | 8. IF UNDER 24 HRS   |  |  |  |  |  |
| Male  |  | White  |  | 7 26 1910  |  | 73 YRS  |  | MONTHS   |  | DAYS   |  | HOURS MIN.                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |  |  |  |  |
| Pennsylvania  |  | U.S.A.   |  |  |  | Baltimore County MD.  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |  |  |
| Rossville   |  | Franklin Square Hospital   |  |  |  | Mechanic-Al Packer Ford   |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE   |  |  |  |  |  |  |  |
| Maryland  |  | Baltimore  |  | Rosedale   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1208 Rosdale Avenue 21237  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST  |  |   |  |  |  |  |  |  |  |  |  |
| Grover  |  |  |  | Hess   |  |   |  | Naona Delt   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |  |  |  |  |
| No  |  | 183-88-0965  |  | Mavis Shiflett   |  | 101 Center Place Apt. 810 Balto., MD. 21222                         |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cerebrovascular accident  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 4360  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| (b)   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |
|   |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |  |  |  |  |  |
|   |  |  |  | P.M. 19  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION  |  |  |  |  |  |  |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 28, 1984, to May 2, 1984, that (we) last saw the deceased alive on May 2, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |
| Lester H. Banks   |  |  |  |  |  |   |  | 5-2-84   |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |  |  |  |  |
| Lester Banks, MD  |  |  |  | 9000 Franklin Square Dr., 21237  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION  |  |  |  |  |  |
| Burial  |  |  |  | 5/5/1984   |  | Gardens Of Faith  |  |  |  | Baltimore Maryland   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | NAME   |  |   |  | 25a. DATE REG.   |  |  |  | 25b. REGISTRAR'S SIGNATURE                   |  |  |  |
| Duda-Ruck, Inc.   |  |  |  | 7922 Wise Avenue Dundalk, MD. 21222  |  |   |  | MAY 7 1984   |  |  |  | Jana Harrison                                |  |  |  |

4354

1006

5-1-1964

1-2-1964

MAY 1 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALVIN N HEWING Jr.</b>                     |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 15 84</b>                             |   | 2b. HOUR<br><b>3 50A M</b>                                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 19 09</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Vice President-Equitable Trust</b> |   |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. STREET ADDRESS<br><b>3606 Rusty Rock Road, 21133</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alvin N. Hewing Sr.</b>              |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ada Elizabeth Chamberlain</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-07-6085</b>   |   | 17. MRS. <b>Susan H. Newman</b> , 2021 Seattle Avenue<br><b>Silver Springs, Maryland 20904</b>            |   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **GRAM NEGATIVE SEPSIS**

4360  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASPIRATION PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CEREBROVASCULAR ACCIDENT**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**HYPERTENSION, C.H.F., ASCVD**

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Hafeez A Syed</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>5/15/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEEZ A SYED</b>  |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>05/17/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery Woodlawn, Baltimore, Md.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>21207</b>  |

24. FUNERAL DIRECTOR  
NAME **Loring Byers Funeral Directors Inc**  
**8728 Liberty Road, Randallstown, Md. 21133**

25a. DATE REC'D. BY REGISTRAR **MAY 22 1984** 25b. REGISTRAR'S SIGNATURE  
**J. H. Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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31

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the funeral director. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 11 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |   |   |  | 8 4 1 2 3 9 0   |   |  |   |  |  |  |
|--|--|--|---|--|--|---|---|---|--|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |  |   |   |   |  | REG. NO.  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |   |  | FIRST MIDDLE LAST<br>Lloyd Lindsay HINTON                                      |   |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 21, 1984  |   | 2b. HOUR<br>5:17P M                                |   |  |  |  |
| 3 SEX<br>MALE  |  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 26 08                                  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS   |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |   |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  |  |   |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF EMPLOYED |   |  |  |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>9 Dihedral Drive 21220  |   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Hinton   |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Painter               |   |   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |  | 16b. SOCIAL SECURITY NO.<br>214-09-7313 |  | 17. INFORMANT<br>Doris Miller 401 Westwind Ct. 21154 Md. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4349 IMMEDIATE CAUSE (a) Coma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Cerebral Infarct-Left Occipital<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cerebral Vascular Disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |   |   |   |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1/a<br>Seizures, Renal Failure, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure  |  |  |   |  |  |   |   |   |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |   |   |   |  |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from May 15, 1984, to May 21, 1984, that (we) last saw the deceased alive on May 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) examine the body after death.   |  |  |   |  |  |   |   |   |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Lawrence R. Bell, MD   |  |  |   |  | 22c. ADDRESS<br>9000 Franklin Square Dr., 21237                                |   |   |   |  | 22d. DATE SIGNED<br>5/21/84   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>5-24-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Pk.                    |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |   |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1984                                   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall |   |  |   |   |  |   |  |  |  |

FBI

CONFIDENTIAL



2/2/54

Handwritten signature or initials.

MAY 28 1954

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 9 1

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                                      |  |  |
|---|--|--|---|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GROVER Howard HITCH</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 21, 1984</b> |   | 2b. HOUR<br><b>2<sup>50</sup> AM</b> |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 30 12</b>   |                                      | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>71</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b>                                  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Social Security Administration</b>   |                                      | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. CITY OR TOWN<br><b>QUEENSTOWN</b>   |   | 13c. STREET ADDRESS / ZIP CODE<br><b>RT 1 BOX 142 21658</b>   |                                      |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward Hitch</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Katherine Pilkington</b>   |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 212-28-6262</b>   |   | 17. INFORMANT ADDRESS<br><b>Doris A. Hitch, Queenstown, MD 21658</b>  |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a:<br><b>RENAL FAILURE, SEPSIS</b>  |  |  |   |   |                                      |  |  |
| 19a. DATE OF OPERATION<br><b>4-30-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CORONARY ARTERY DISEASE</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>4-29 84 5-20 84</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                      |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>4-29 84 5-20 84</b>  |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-29 84</b> to <b>5-20 84</b> , that (I) (we) last saw the deceased alive on <b>5-20 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                                      |  |  |
| 22b. SIGNATURE<br><b>G.R. McDonald</b>  |  | DEGREE<br><b>MB.Ch.B. FRACS</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |                                      | 22c. DATE SIGNED<br><b>5-21-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr G.R. McDonald</b>  |  |  |   | 22e. ADDRESS<br><b>St Joseph Hospital</b>   |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>05/24/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD Veteran's Cemetery</b>  |                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Hurlock Dorchester MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Tom Helfenbein Funeral Homes, Chester, MD 21619</b>   |  |  |   | 25a. DATE REG'D. BY REGISTRAR<br><b>MAY 29 1984</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE HOLDEN LAST   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 6, 1984 |   |  | 2b. HOUR<br>12:25 AM   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 16 07   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MINS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sec'y                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>City Health   |  |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE CITY OR TOWN<br>Md. Towson   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS / ZIP CODE<br>Stella Maris Hosp. 21204  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James S. Holden  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Kelly            |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  |  |  |
| 17a. SOCIAL SECURITY NO.<br>214-40-2638  |  |  | 17. INFORMANT<br>Ms. Ilene Wintz                                       |   |  | 17b. ADDRESS<br>1341 E. Northern Balto., Md. Pkwy.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a):<br>4300<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Subarachnoid hemorrhage<br>(b):<br>Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c):  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>S. J. [Signature]<br>DEGREE  |  |  |  |   |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. J. [Signature]   |  |  |  |   |  | 22e. ADDRESS<br>2300 Pulaski Valley Rd 21204  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  |  | 23b. DATE<br>5/6/84  |   | 23c. NAME OF CEMETERY OR CREMATORY                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 9 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 9 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JERRY WAYNE HOLT</b>                    |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 26 84</b>                                      |   | 2b. HOUR<br><b>3:50A</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 13 46</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MD</b>                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES STREET</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mgt. Consultant</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Alexander Proudfoot</b> |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Reisterstown</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>326 Norgulf Road 21136</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Delacey E. Holt</b>                  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Reva Spruce</b>                        |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br><b>212-46-4227</b>  |  | 17. INFORMANT<br><b>Carol L. Holt</b>   |   |
| ADDRESS <b>326 Norgulf Road Reisterstown, MD 21136</b>                            |   |   |  |   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

5860 IMMEDIATE CAUSE (a) **HYPOTENSION**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION<br><b>5/25/84</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RENAL FAILURE</b>   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><i>Uberoi</i>   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>5/26/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. S. UBEROI</b>  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES STREET</b>                             |  |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>5/29/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>        |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1984</b>             | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |
| 7922 Wise Avenue, Dundalk, MD 21222                           |                             |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 2 3 9 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |   |   |   |   |  |
|--|--|--|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Otis Emory HOPPER, Sr.  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-10-84                                   |   |   | 2b. HOUR<br>1639 M  |   |   |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 22 18   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Policeman   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>Owings Mills   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>26 S Ritters Lane 21117 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Otis E Hopper  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Avis Park                       |   |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II<br>212-07-1316 |   | 17. INFORMANT<br>ADDRESS<br>Agnes Hopper<br>26 S. Ritters Lane<br>Owings Mills, Md. 21117 |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4140 IMMEDIATE CAUSE (a) CAROTID PULMONARY Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CORONARY Artery Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Atherosclerotic Cardiovascular Disease      |  |  |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br>Hypertension, Hypertriglyceridemia   |  |  |  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION<br>Not done   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-14, 1983, to 5-10, 1984, that (I) (we) lost<br>saw the deceased alive on 4-16-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |   |   |  |
| 22b. SIGNATURE<br>GARY A MANKO   |  |  | DEGREE<br>MD   |   |   | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>5-10-84   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GARY A. MANKO   |  |  | 22e. ADDRESS<br>11722 Reisterstown Rd, Reisterstown, MD 21136                    |   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>May 14, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park                                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |   |   |  |
| 24. FUNERAL DIRECTOR<br>H. J. Edelhardt  |  |  | ADDRESS<br>Owings Mills, Md 21117  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |   |   |  |

This certificate must be completed at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BESSIE A HUBBARD</b>   |  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 29 84</b> |   |  | 26. HOUR<br><b>10.15 AM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 10 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>COUNTY - BALTIMORE MD.</b>              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSP.</b>                 |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  | 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES TRICE</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARTHA AOKINS</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>9630 N. 11th Ave. 21234</b>                   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-2185</b>   |   | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4402</b> IMMEDIATE CAUSE (a) <b>Respiration, Cardiac Arrest</b>   |  |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Respiratory arrest, Atherosclerotic disease</b>  |  |  |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>GANGRENE - RT FOOT</b>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>5.22.84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gangrene Foot</b>   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4.5</b> , 19 <b>84</b> , to <b>5.29</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>5.29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>James</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>5.29.84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MIRZA M. AHMAD</b>  |  |  |   | 22e. ADDRESS<br><b>ST. JOSEPH HOSP. TOWSON 21204</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAY 31 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MARYLAND</b>     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPLAIN OF MEMORISS</b>   |  |  |   | ADDRESS<br><b>8800 HARFORD ROAD</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1984</b>                                 |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>  |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |  |   |
|--|--|--|---|
| FOR<br>1 - STATE<br>REGISTRAR  |  | REG. NO. 1   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES HUNT   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>05 13 84<br>2b. HOUR<br>5:30 P.M.  |   |
| 3. SEX<br>Male   | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 05 1920  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA            | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   | 10. CITY OR TOWN OF DEATH<br>Randallstown                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Gen Hosp |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPER INTENDENT  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PRINTING                          | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland                 |   |
| 13c. COUNTY<br>Baltimore   | 13d. CITY OR TOWN<br>Randallstown                                      | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13f. STREET ADDRESS / ZIP CODE<br>8614 Bramble Lane, 21133  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>OSCAR HUNT   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>AMY MORGAN            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW II                          |   |
| 16b. SOCIAL SECURITY NO.<br>214-62-4574  | 17. INFORMANT<br>ELIZABETH HUNT  | ADDRESS<br>RANDALLSTOWN, MD.<br>8614 BRAMBLE LANE 21133  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Metastatic Nonresectable Squamous Cell Carcinoma of Tongue   |  |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 84 to May 13 19 84, that (I) (we) last saw the deceased alive on May 14 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.                                     |  |  |   |
| 22b. SIGNATURE<br>Marshall A. Levine   | DEGREE<br>MD   | 22c. DATE SIGNED<br>5/13/84  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marshall A. Levine   |
| 22e. ADDRESS<br>711 W. 40th St. Baltimore, MD, 21211   | 22f. ADDRESS<br>711 W. 40th St. Baltimore, MD, 21211                   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>05-16-84  | 23c. NAME OF CEMETERY OR CREMATORY<br>CREST LAWN MEM. GARD.  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MARRIOTTSTVILLE HOWARD MD.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.   | ADDRESS<br>4107 WILKENS AVE.   | 25a. DATE RECEIVED BY REGISTRAR<br>MAY 15 1984   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13

Male

Adult

Remission

Mar 1941 - 1st time

Physiological Information

Metabolic processes of the organism

1st part

AD

Marshall A. Levine

Mar 1941 - 1st time

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, THE MEDICAL EXAMINER MUST WRITE "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME FOR EXECUTION OF THE CERTIFICATE. RETURN PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO.  |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
| Claude  |  | K.  |  | Hunter  |  |   |  | 5/2/84 19   |  | M   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | 7. IF UNDER 1 YR.   |  | 7b. HOUR  |  |
| Male  |  | White   |  | April 16, 1926  |  | 58 YRS.   |  | MONTHS DAYS HOURS MIN.  |  | 0:35  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | XX NEVER MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | P M   |  |
| Virginia  |  | USA   |  | WIDOWED   |  | DIVORCED  |  | Baltimore County  |  | MD  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |
| Randallstown  |  | Baltimore County General Hosp.  |  | Supervisor-Retired  |  | Kodak   |  |   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland  |  | Baltimore   |  | Woodlawn  |  | YES NO  |  | 1940 Winder Road  |  | 21207   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |
| Claude K. Hunter  |  | Claudia O. Cooper   |  | 224-20-2040   |  | RUBY J. HUNTER, SAME AS 13  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19. DEATH WAS CAUSED BY:  |  | 20. AUTOPSY?  |  | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 22. LOCATION  |  |   |  |
| Arteriosclerotic Cardiovascular Disease   |  | IMMEDIATE CAUSE (a)   |  | YES NO  |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2  |  | CITY OR TOWN  |  |   |  |
| 4292  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  | COUNTY  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  | (b)   |  |   |  |   |  | STATE   |  |   |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |
|   |  | (c)   |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?  |  | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 22. LOCATION  |  |   |  |
|   |  |   |  | YES NO  |  |   |  | CITY OR TOWN  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. LOCATION   |  | 21e. PLACE OF INJURY  |  |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  |   |  | STREET  |  | STREET, FACTORY, FARM, ETC.)  |  |   |  |
| 21f. INJURY OCCURRED WHILE NOT WHILE AT WORK  |  | 21g. PLACE OF INJURY  |  | 21h. LOCATION   |  | 21i. PLACE OF INJURY  |  | 21j. LOCATION   |  |   |  |
|   |  | STREET, FACTORY, FARM, ETC.)  |  | STREET  |  | CITY OR TOWN  |  | COUNTY  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  |   |  |   |  |   |  |   |  |   |  |
| 22b. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22c. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22d. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22e. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22f. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22g. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  |
| 22h. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22i. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22j. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22k. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22l. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22m. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  |
| 22n. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22o. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22p. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22q. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22r. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22s. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  |
| 22t. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22u. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22v. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22w. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22x. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22y. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  |
| 22z. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  | 22aa. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ab. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ac. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ad. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ae. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  |
| 22af. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ag. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ah. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ai. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22aj. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner. |  | 22ak  |  |



OWNED BY

RECEIVED

*[Handwritten signature]*

BY: *[Handwritten signature]*